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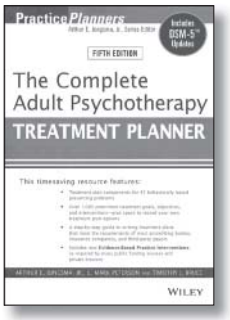


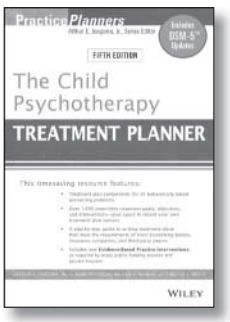


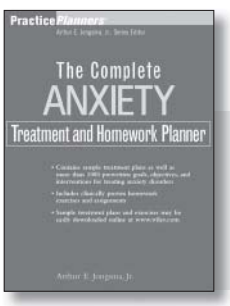


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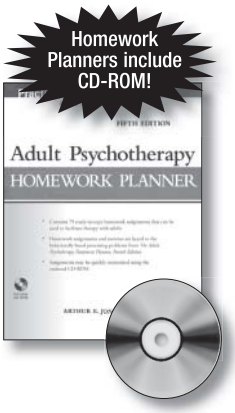


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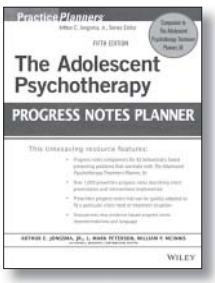


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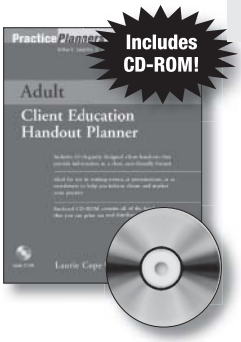


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# The Crisis Counseling and Traumatic Events Treatment Planner, with DSM-5 Updates, Second Edition

*Tammi D. Kolski*

*Arthur E. Jongsma, Jr.*

*Rick A. Myer, Contributing Editor*

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*As my only child transitions into college, the support and love from my husband continues to encourage and enrich my life.*
*Thank you, Russ and Ashleigh, for your heartfelt commitment to our family.*

*— TDK*

*To new friends, Rodger and Ruth, who have significantly enriched our lives when we have learned to value such friendships as gifts from God.*

*— AEJ*

*To my family—my wife, Sarah, and daughters, Melinda and Allison.*
*Thank you for the support and patience.*

*— RAM*

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# PRACTICE*PLANNERS*® SERIES PREFACE

Accountability is an important dimension of the practice of psychotherapy. Treatment programs, public agencies, clinics, and practitioners must justify and document their treatment plans to outside review entities in order to be reimbursed for services. The books in the Practice*Planners*® series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

The Practice*Planners*® series includes a wide array of treatment planning books including not only the original *Complete Adult Psychotherapy Treatment Planner*, *Child Psychotherapy Treatment Planner*, and *Adolescent Psychotherapy Treatment Planner*, all now in their fifth editions, but also *Treatment Planners* targeted to specialty areas of practice, including:

- Addictions
- Co-occurring disorders
- Behavioral medicine
- College students
- Couples therapy
- Crisis counseling
- Early childhood education
- Employee assistance
- Family therapy
- Gays and lesbians
- Group therapy
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- Mental retardation and developmental disability
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- Women's issues

In addition, there are three branches of companion books that can be used in conjunction with the *Treatment Planners*, or on their own:

- ***Progress Notes Planners*** provide a menu of progress statements that elaborate on the client's symptom presentation and the provider's therapeutic intervention. Each *Progress Notes Planner* statement is directly integrated with the behavioral definitions and therapeutic interventions from its companion *Treatment Planner*.
- ***Homework Planners*** include homework assignments designed around each presenting problem (such as anxiety, depression, substance use, anger control problems, eating disorders, or panic disorder) that is the focus of a chapter in its corresponding *Treatment Planner*.
- ***Client Education Handout Planners*** provide brochures and handouts to help educate and inform clients on presenting problems and mental health issues, as well as life skills techniques. The handouts are included on CD-ROMs for easy printing from your computer and are ideal for use in waiting rooms, at presentations, as newsletters, or as information for clients struggling with mental illness issues. The topics covered by these handouts correspond to the presenting problems in the *Treatment Planners*.

The series also includes adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook*, containing forms and resources to aid the clinician in mental health practice management.

The goal of our series is to provide practitioners with the resources they need in order to provide high-quality care in the era of accountability. To put it simply: We seek to help you spend more time on patients, and less time on paperwork.

ARTHUR E. JONGSMA, JR.
*Grand Rapids, Michigan*

# ACKNOWLEDGMENTS

While the content of the first edition of this book is far from outdated, it was time to upgrade to maintain a quality, evidence-based resource consistent with the other treatment planning books in this spectacular series. The intuitiveness of the Wiley editors in asking for this book to be revised could not have come at a better time for me personally. I am grateful to Rick Myer for his willingness on short notice to lend his expertise for this project's completion. Art Jongsma has been a trusted mentor and friend of mine for many years and it has again been my pleasure to co-author this book with him. Being involved with editors and authors who share one vision allows us the opportunity to help bring peace to those in times of distress.

—TDK

Through the years of being a contributor to the *Treatment Planner* series, I have collaborated with many very knowledgeable professionals. Now, I want to acknowledge my addition of another *friend* to the list of professionals who clearly know their field and want to help others get up to speed. My thanks go out to Rick Myer, a true crisis specialist, for seeing this evidence-based treatment revision process to completion. You were, indeed, a gracious and expert collaborator.

To my former colleague, Tammi Kolski, an author from the first edition, I extend my hand of thanks for prompt and good work on the chapters she revised. She is a veteran with the *Treatment Planner* style and format and it shows in her mastery of the content presentation. Your work shows strong dedication to using best practice methods within a relationship of compassion to help those who are vulnerable after a crisis.

I also want to acknowledge the good and consistent work of our manuscript manager, Sue Rhoda, who irons out all the wrinkles and sends in a manuscript that looks clean and well pressed. Sue, you are the best and I am so pleased to be able to work with you.

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worked with for 17 years now. I count several of these fine people among my friends who enrich my life.

—AEJ

A book of this nature relies heavily not only on training, but also on having practiced what you preach. Thank you to everyone who has helped me to understand the science and art of crisis intervention and trauma therapy. The obvious people in this group are my supervisors and professors. However, the less obvious groups include the students to whom I have taught crisis intervention over the past 25 years. I learn something each time I teach the course. I also wish to acknowledge all the people that I worked with in the field, including clients as well as colleagues. I was privileged to offer support and assistance to those in need, but also to have learned from you. And finally, thank you to my colleagues; I appreciate your guidance and support.

—RAM

# The Crisis Counseling and Traumatic Events Treatment Planner, with DSM-5 Updates, Second Edition

# INTRODUCTION

## ABOUT PRACTICE*PLANNERS*® TREATMENT PLANNERS

Pressure from third-party payors, accrediting agencies, and other outside parties has increased the need for clinicians to quickly produce effective, high-quality treatment plans. *Treatment Planners* provide all the elements necessary to quickly and easily develop formal treatment plans that satisfy the needs of most third-party payors and state and federal review agencies.

Each *Treatment Planner:*

- Saves you hours of time-consuming paperwork.
- Offers the freedom to develop customized treatment plans.
- Includes over 1,000 clear statements describing the behavioral manifestations of each relational problem, and includes long-term goals, short-term objectives, and clinically tested treatment options.
- Has an easy-to-use reference format that helps locate treatment plan components by behavioral problem or *DSM-5* diagnosis.

As with the rest of the books in the Practice*Planners*® series, our aim is to clarify, simplify, and accelerate the treatment planning process, so you spend less time on paperwork, and more time with your clients.

## ABOUT THE CRISIS COUNSELING AND TRAUMATIC EVENTS TREATMENT PLANNER

Since the publication of the first edition of this *Treatment Planner* in 2001, the world has changed. The dramatic terrorists' attacks of 9/11 shocked the world, leaving professionals wondering how best to help survivors, the disaster of Hurricane Katrina and the ineffective response reverberated through the United States in particular southern states, the tragedies at Virginia Tech and Northern Illinois University severely taxed the resources

of those schools, the wars in Iraq and Afghanistan have left military personnel and their families disoriented and in crisis, to mention some of the more sensational of traumatic events. Hundreds of lesser crises and traumatic events have taken place, each leaving in its wake people who are attempting to make sense and meaning of the respective crisis. The need for effective and efficient crisis intervention and trauma counseling has never been greater. At the same time, professionals have embraced the idea that early intervention prevents long-term mental health issues. This increased emphasis in early intervention, along with the myriad of crisis events, was the catalyst for revising this *Treatment Planner*.

In the past 25 years, crisis intervention and trauma counseling has become a specialty just as any other specialty in the mental health field (Roberts, 2005). Although the same basic skills are used, these are used in very different ways than in other types of counseling (James & Gilliland, 2012). Crisis intervention and trauma counseling is a fluid process in which help must be given, and given immediately. You do not have the luxury of allowing the therapeutic relationship to unfold. You must be prepared to work quicker and at times become directive with clients. Assessment must be swift and infused throughout the entire intervention in order to meet the ever-changing, fluid needs of clients (Myer, 2001). Interventions vary from non-directive to collaborative to directive (James & Gilliland, 2012). At times, you must even be prepared to allow clients to be dependent on you until they have reactivated coping mechanisms and can access the resources need for recovery.

Objectives and interventions in this edition reflect the latest research and practices in crisis intervention and trauma counseling. For example, you will notice that some objectives focus on assisting clients to recognize ways they might have grown from the crisis or trauma rather than solely on negative symptoms. Elements from the previous edition that manifest best practices have also been retained. A chapter on Bullying has been added to this edition, making a total of 27 chapters for the second edition.

This book goes hand-in-hand with several chapters from other *Treatment Planner* volumes, most notably the Posttraumatic Stress Disorder chapter from *The Complete Adult Psychotherapy Treatment Planner* (Jongsma, Peterson, & Bruce, 2006), *The Complete Adolescent Psychotherapy Treatment Planner* (Jongsma, Peterson, McInnis, & Bruce, 2006a), and *The Complete Child Psychotherapy Treatment Planner* (Jongsma, Peterson, McInnis, & Bruce, 2006b). Please understand that not everyone who experiences a crisis or traumatic event develops Posttraumatic Stress Disorder (PTSD). In fact, the vast majority of cases do not result in symptoms meriting a PTSD diagnosis. This volume is designed to help you provide treatment to everyone, especially those who are not diagnosable with PTSD.

## INCORPORATING EVIDENCE-BASED TREATMENT INTO THE *TREATMENT PLANNER*

Evidence-based or empirically supported treatment (that is, treatment that has shown efficacy in research trials) is rapidly becoming of critical importance to the mental health community as the demand for quality and accountability increases. Indeed, identified empirically supported treatments (e.g., those of the APA Division 12 [Society of Clinical Psychology], the Substance Abuse and Mental Health Services Administration's [SAMHSA] National Registry of Evidence-based Programs and Practices [NREPP]) are being referenced by a number of local, state, and federal funding agencies, some of which are beginning to restrict reimbursement to these treatments, as are some managed care and insurance companies.

In this second edition of *The Crisis Counseling and Traumatic Events Treatment Planner*, we have made an effort to empirically inform some chapters by highlighting Short-Term Objectives (STOs) and Therapeutic Interventions (TIs) that are consistent with psychological treatments or therapeutic programs that have demonstrated some level of efficacy through empirical study. Watch for this icon as an indication that an Objective/Intervention is consistent with those found in evidence-based treatments (EB).

References to the empirical work supporting these interventions have been included in the reference section as Appendix B. For information related to the identification of evidence-based therapies (EBTs), including the benefits and limitations of the effort, we suggest the APA Presidential Task Force on Evidence-Based Practice (2006), Bruce and Sanderson (2005); Chambless et al. (1996, 1998); Chambless and Ollendick (2001); Castonguay and Beutler (2006); Drake, Merrens, and Lynde (2005); Hofmann and Tompson (2002); Nathan and Gorman (2007); and Stout and Hayes (2005).

In this *Planner*, we have included STOs and TIs consistent with identified EBTs for crises and traumatic events commonly seen by practitioners in public agency and private practice settings. It is important to note that the empirical support for the EBT material found in each chapter has *not* necessarily been established for treating that problem within the context of a crisis or traumatic event, but rather is particular to the problem identified in the chapter title. Understand that EBTs such as on Cognitive-Behavioral Therapy can be applied to a wide variety of problems. For example, the STOs and TIs consistent with cognitive therapy that have been well established as an empirically supported individual treatment for modifying negative to positive self talk are found throughout the chapters in this edition. Therefore, many chapters present common crises faced by children, adolescents, and adults (e.g., school or workplace violence, disasters) for which few to no studies have specifically focused on treatment. In these situations an EBT technique, such as cognitive restructuring or problem-solving skills, can be utilized to help these people through that particular challenge.

Beyond references to the empirical studies supporting these interventions, we have provided references to therapist- and client-oriented books and treatment manuals that describe the use of identified EBTs or treatments consistent with their objectives and interventions. Of course, recognizing that there are STOs and TIs that practicing clinicians have found useful but that have not yet received empirical scrutiny, we have included those that reflect common best practice among experienced clinicians. The goal is to provide a range of treatment plan options, some studied empirically, others reflecting common clinical practice, so the user can construct what they believe to be the best plan for a particular client. Most of the STOs and TIs associated with the EBTs are described at a level of detail that permits flexibility and adaptability in their specific application. As with all *Planners* in this series, each chapter includes the option to add STOs and TIs at the therapist's discretion.

## Criteria for Inclusion of Evidence-Based Therapies

The EBTs from which STOs and TIs were taken have different levels of empirical evidence supporting them. For example, some have been well established as efficacious for the problems that they target (e.g., exposure-based therapies for anxiety disorders). Others have less support, but nonetheless have demonstrated efficacy. We have included EBTs the empirical support for which has either been well established or demonstrated at more than a preliminary level as defined by those authors who have undertaken the task of identifying them, such as the APA Division 12 (Society of Clinical Psychology), Drake and colleagues (2003, 2005), Chambless and colleagues (1996, 1998), and Nathan and Gorman (2007).

At minimum, efficacy needed to be demonstrated through a clinical trial or large clinical replication series with features reflecting good experimental design (e.g., random assignment, blind assignments, reliable and valid measurement, clear inclusion and exclusion criteria, state-of-the-art diagnostic methods, and adequate sample size or replications). Well-established EBTs typically have more than one of these types of studies demonstrating their efficacy, as well as other desirable features such as demonstration of efficacy by independent research groups and specification of client characteristics for which the treatment was effective.

Lastly, all interventions, empirically supported or not, must be adapted to the particular client in light of his/her personal circumstances, cultural identity, strengths, and vulnerabilities. The STOs and TIs included in this *Planner* are written in a manner to suggest and allow this adaptability.

### Summary of Required and Preferred EBT Inclusion Criteria

*Required*

- Demonstration of efficacy through at least one randomized controlled trial with good experimental design, or
- Demonstration of efficacy through a large, well-designed clinical replication series.

*Preferred*

- Efficacy has been shown by more than one study.
- Efficacy has been demonstrated by independent research groups.
- Client characteristics for which the treatment was effective were specified.
- A clear description of the treatment was available.

## HOW TO USE THIS *TREATMENT PLANNER*

Use this *Treatment Planner* to write treatment plans according to the following progression of six steps:

1. **Problem Selection.** Although the client may discuss a variety of issues during the assessment, the clinician must determine the most significant problems on which to focus the treatment process. Usually a primary problem will surface, and secondary problems may also be evident. Some other problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can only deal with a few selected problems or treatment will lose its direction. Choose the problem within this *Planner* that most accurately represents your client's presenting issues.
2. **Problem Definition.** Each client presents with unique nuances as to how a problem behaviorally reveals itself in his or her life. Therefore, each problem that is selected for treatment focus requires a specific definition about how it is evidenced in the particular client. The symptom pattern should be associated with diagnostic criteria and codes such as those found in the *DSM-5* or the *International Classification of Diseases*. This *Planner* offers such behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements.
3. **Goal Development.** The next step in developing your treatment plan is to set broad goals for the resolution of the target problem. These statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures. This *Planner* provides several possible goal statements for each problem, but one statement is all that is required in a treatment plan.

4. **Objective Construction.** In contrast to long-term goals, objectives must be stated in behaviorally measurable language so that it is clear to review agencies, health maintenance organizations, and managed care organizations when the client has achieved the established objectives. The objectives presented in this *Planner* are designed to meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem.
5. **Intervention Creation.** Interventions are the actions of the clinician designed to help the client complete the objectives. There should be at least one intervention for every objective. If the client does not accomplish the objective after the initial intervention, new interventions should be added to the plan. Interventions should be selected on the basis of the client's needs and the treatment provider's full therapeutic repertoire. This *Planner* contains interventions from a broad range of therapeutic approaches, and we encourage the provider to write other interventions reflecting his or her own training and experience.

   Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix A contains a full bibliographic reference list of these materials. For further information about self-help books, mental health professionals may wish to consult *The Authoritative Guide to Self-Help Resources in Mental Health, Revised Edition* (2003) by Norcross et al. (available from Guilford Press, New York).
6. **Diagnosis Determination.** The determination of an appropriate diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents with the criteria for diagnosis of a mental illness condition as described in *DSM-5*. Despite arguments made against diagnosing clients in this manner, diagnosis is a reality that exists in the world of mental health care, and it is a necessity for third-party reimbursement. It is the clinician's thorough knowledge of *DSM-5* criteria and a complete understanding of the client assessment data that contribute to the most reliable, valid diagnosis.

Congratulations! After completing these six steps, you should have a comprehensive and individualized treatment plan ready for immediate implementation and presentation to the client. A sample treatment plan for the crime victim is provided at the end of this introduction.

## A FINAL NOTE ON TAILORING THE TREATMENT PLAN TO THE CLIENT

One important aspect of effective treatment planning is that each plan should be tailored to the individual's client's problems and needs. Treatment plans should not be mass-produced, even if clients have similar problems. The individual's strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns must be considered in developing a treatment strategy. Drawing upon our own years of clinical experience, we have put together a variety of treatment choices. These statements can be combined in thousands of permutations to develop detailed treatment plans. Relying on their own good judgment, clinicians can easily select the statements that are appropriate for the individuals whom they are treating. In addition, we encourage readers to add their own definitions, goals, objects, and interventions to the existing samples. As with all of the books in the *Treatment Planners* series, it is our hope that this book will help promote effective, creative treatment planning—a process that will ultimately benefit the client, clinicians, and mental health community.

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# SAMPLE TREATMENT PLAN

## PRIMARY PROBLEM: CRIME VICTIM

### BEHAVIORAL DEFINITIONS

1. Exposure to a crime that involved the threatened death or serious injury or loss to self related to a workplace robbery.
2. Recurrent, intrusive, traumatic memories, flashbacks, and nightmares related to crime.
3. Difficulty in concentrating and following directions following the crime.
4. Increased use of alcohol or other mood altering substances following the crime.
5. Persistent fear of death or personal injury occurring to self.
6. Experiencing suspiciousness and mistrust of others following the crime to the point that it interferes with daily functioning.
7. Social withdrawal and isolation, avoidance of certain locations.
8. Inability to regulate emotions following the crime.
9. Disruption of typical sleep patterns following the crime.

### LONG-TERM GOALS

1. Return to pre-crisis level of functioning including resumption of routine daily activities.
2. Restore appropriate levels of emotional, behavioral, and cognitive functioning.

### SHORT-TERM OBJECTIVES

1. Cooperate with completing objective assessment instruments.

### THERAPEUTIC INTERVENTIONS

1. Administer to the client assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Symptom Checklist 90, Trauma Symptom Checklists) to guide intervention that is needed.

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| 2. Explore perceptions of the traumatic incident. | 1. Assure the client of his/her safety and use active listening skills to explore affective, behavioral, and cognitive reactions while he/she discusses the crime in as much detail as he/she is comfortable with (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma). |
| 3. Share facts, thoughts, and feelings about the crime with trusted family members and friends. | 1. Assist the client in identifying trusted family members and friends with whom the crime experience can be shared.<br>2. Encourage and facilitate the client sharing affective and cognitive reactions with a professional therapist, family member, and/or trusted friend.<br>3. Role-play with the client disclosing information about the crime to different people in the community; process the reactions to the exercise. |
| 4. Report confidence in personal actions taken during the incident rather than second-guessing these. | 1. Explore the client's feelings and thoughts that he/she experienced before and during the crime; reassure him/her of the typical automatic behavioral and emotional responses that occur in these crisis situations.<br>2. Redirect the client's negative evaluation to a realistic, non-judgmental evaluation of his/her behavior by focusing on the facts of what took place during the crime and his/her understandable response. |
| 5. Decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the event. | 1. Assess the client for increased use of alcohol and other mood-altering substances following the event that are used as a means of coping with the trauma; continue |

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| | to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary. |
| 6. Learn and implement calming and coping strategies to manage the anxious reactions to the crime. | 1. Teach the client strategies from stress inoculation training, such as breathing control, to manage unrealistic fears regarding the crime. |
| 7. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk about the crime. | 1. Explore the client's schema and self-talk that causes incident-related fears; challenge negative biases and assist him/her in generating appraisals that correct for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).<br>2. Assign the client a homework exercise (e.g., journaling or writing and reviewing flash cards with positive self-talk) in which he/she identifies fearful self-talk about the crime and creates reality-based alternatives; review and reinforce success, providing corrective feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma). |
| 8. Participate in imaginal and in vivo exposure to trauma-related memories until thinking about the trauma does not result in marked distress. | 1. Direct and assist the client in constructing a fear and avoidance hierarchy of trauma-related stimuli.<br>2. Assign the client homework exercises in which he/she engages in exposure exercises to stimuli that evoke reactions similar to that experienced during the crime and records responses (see "Gradually Reducing Your Phobic Fear" in the *Adult* |

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| | *Psychotherapy Homework Planner*, 2nd ed. by Jongsma).<br>3. Reduce anxiety regarding the crime by having the client use imaginal exposure to the trauma through describing the crime at an increasing but client-chosen level of detail; repeat until associated anxiety stabilizes; review and reinforce progress; problem-solve obstacles. |
| 9. Develop healthy communication skills when discussing the crime with family members. | 1. Teach family members healthy communication skills (e.g., reflective listening, eye contact, respect, etc.) to be used when discussing the crime.<br>2. Use cognitive behavioral techniques (modeling, role-playing, corrective feedback, and positive reinforcement) to teach the family communication skills including assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner. |

## DIAGNOSIS:

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 308.3 | F43.0 | Acute Stress Disorder |

# ACUTE STRESS DISORDER

## BEHAVIORAL DEFINITIONS

1. Has been exposed to actual death of another or perceived death or serious injury to self or another that resulted in an intense emotional response of fear, helplessness, or horror.
2. Experiences an initial state of daze with dissociative symptoms of numbing, detachment, derealization, depersonalization, narrowing of attention, amnesia, or narrowing of attention, inability to comprehend stimuli, and disorientation.
3. Re-experiences the event in thoughts, dreams, illusions, flashbacks, or recurrent images.
4. Demonstrates marked avoidance of stimuli that vivify recollections of the event; whether through thoughts, feelings, conversations, activities, places, or people.
5. Exhibits symptoms of anxiety, impaired judgment, confusion, and depression.
6. Displays symptoms of increased arousal such as difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness, and agitation.
7. Experiences physical symptoms of chest pain, chest pressure, sweating, shortness of breath, constricting of blood vessels, headache, flushing, muscle tension, intestinal upset, heart palpitation, or dry mouth.

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## LONG-TERM GOALS

1. Stabilize physical, cognitive, behavioral, and emotional reactions to the trauma while increasing the ability to function on a daily basis.
2. Diminish intrusive images and the alteration in functioning or activity level that is due to stimuli associated with the trauma.
3. Assimilate the traumatic event into daily life experiences without ongoing distress.
4. Forgive the perpetrator of the traumatic event.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Remove self from the traumatic event environment. (1) | 1. Direct the client to a triage location away from direct exposure to the traumatic event. |
| 2. Describe any bodily injury or physical symptoms that have begun since the traumatic event. (2, 3) | 2. Assist in getting the client to his/her physician, urgent care, or emergency department for a medical evaluation.<br>3. Validate for the client how the body can physically react to stress. |
| 3. Complete screening tools to identify the occurrence of dissociative symptoms. (4) | 4. Have the client complete a screening instrument to determine his/her sense of orientation and the degree to which dissociative symptoms are occurring (e.g., Mini Mental State Examination, 2nd ed. or Dissociative Experiences Scale). |
| 4. Describe the traumatic event, providing as much detail as comfort allows. (5, 6) | 5. Prompt the client to describe the traumatic experience within the session noting whether he/she is |

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| | overwhelmed with emotions. Out of session, have the client write facts remembered of the event; process in session his/her emotions and provide supportive feedback toward symptom reduction. |
| | 6. Obtain a release of information to appropriate agencies (law enforcement, health care professionals, school personnel, relatives, coworkers) and consult with those who have factual details of the event, to corroborate and/or elaborate on the client's recall of the traumatic event. |
| 5. Verbalize an understanding of distorted cognitive messages that promote fear, worry, or anxiety and its treatment. (7, 8) | 7. Discuss facts of the trauma to explore the client's possible distorted cognitive messages that intensify the negative emotional reactions to the trauma. |
| | 8. Help the client develop reality-based cognitive messages that will increase self-confidence and facilitate a reduction in fear, worrying, or anxiety responses. |
| 6. Describe the feelings that were experienced at the time of the trauma and how daily functioning has been impacted. (9, 10, 11) | 9. Actively build the level of trust with the client in individual sessions through consistent eye contact, unconditional positive regard, and warm acceptance to explore his/her emotional reaction at the time of the trauma. |
| | 10. Develop with the client a symptom development time line to identify how the traumatic event has negatively impacted his/her life. |
| | 11. Assess the client's frequency, intensity, and duration of |

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| | traumatic reactions on his/her emotional, cognitive, and behavioral functioning (e.g., using an objective instrument such as Trauma Symptom Inventory–2). |
| 7. Implement behavioral strategies to reduce physical stress reactions. (12, 13) | 12. Develop and reinforce a routine of physical exercise (e.g., brisk walk, step aerobics, bike riding) that will ameliorate physical stress reactions; reinforce success. |
| | 13. Explore the reduction of tension by the client scheduling activities that involve their physical engagement; reinforce his/her participation in the activities and encourage the integration of the activities into daily life. |
| 8. Learn and implement the thought-stopping technique to manage intrusive unwanted thoughts. (14, 15) | 14. Explore whether the client has had any flashback experiences to this trauma or previous traumatic events; assign a homework exercise of writing recurring images or memories associated with the trauma; process in session. |
| | 15. Teach the client to implement a thought-stopping technique (thinking of a stop sign, yelling *STOP* only in the mind, and then imagining a pleasant scene) immediately upon experiencing unwanted thoughts; monitor and encourage the client's use of the technique in daily life between sessions. |
| 9. Cooperate with an evaluation by a physician for psychotropic medication. (16, 17) | 16. Refer the client to a physician for a psychotropic medication evaluation. |
| | 17. Obtain a release of information from the client to allow for regular consultation with the |

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| | prescribing physician; monitor the client's psychotropic medication compliance, side effects, and effectiveness. |
| 10. Learn and implement relaxation techniques to reduce cognitive, emotional, and/or behavioral stress reactions. (18, 19, 20) | 18. Teach the client relaxation skills (e.g., self-guided imagery, progressive muscle relaxation, deep rhythmic breathing) and how to apply these skills to his/her daily life. |
| | 19. Utilize biofeedback techniques to facilitate the client learning relaxation skills; monitor compliance and effectiveness while providing corrective feedback toward improvement. |
| | 20. Refer the client for acupuncture to relieve symptoms of stress; review success. |
| 11. Cooperate with eye movement desensitization and reprocessing (EMDR) technique to reduce emotional reactions to the traumatic event. (21) | 21. Utilize EMDR exposure technique to reduce the client's emotional reactivity to the traumatic event. |
| 12. Avoid the geographic area surrounding the traumatic event. (22) | 22. Ask the client to identify alternative routes that would prohibit exposure to the place of the traumatic event to avoid overwhelming stress reactions associated with exposure to the scene of the trauma. |
| 13. Maintain involvement in social and vocational activities, assimilating the traumatic event into daily living. (23) | 23. Encourage the client to return to work, social engagements, and/or daily routines that occurred prior to the traumatic event; if necessary, phase these activities into daily living gradually but steadily. |
| 14. Identify and replace feelings of survivor guilt with positive, realistic, and empowering self-talk. (24, 25, 26) | 24. Explore the client's depiction of survivor guilt and occurrence of self-talk that triggers the guilt feelings. |

25. Nurture the client's entitlement to enjoy life as a countermeasure to his/her sense of survivor guilt.

26. Assist the client in replacing feelings of survivor guilt by assigning a homework exercise in which he/she identifies guilt-inducing self-talk; assist the client in creating reality-based alternatives; process in session effectiveness of reducing feelings of survivor guilt.

15. Learn and implement relapse prevention strategies for emotional reactions on the anniversary day of the event or major live events (holidays, birthdays, graduation). (27, 28, 29)

27. Utilize stress inoculation training including such aspects as psychoeducation, calming and coping skills training, assertiveness skill training, guided self-dialogue (see *Stress Inoculation Training* by Meichenbaum) to help the client prepare in advance to handle stressful events successfully and with a minimum of upset.

28. Identify and rehearse with the client the management of increased emotional reactions associated with future situations or circumstances (e.g., event anniversary date, holidays, etc.)

29. Prompt the client to talk about how the negative emotional reactions to the trauma have increased with the approaching anniversary of the event or other future major life events (e.g., holidays, vacation, graduation, etc.). Design an activity to be implemented on that day; process the completed assignment.

16. Return to the scene of the event to manage anxiety response. (30, 31, 32)

30. Assist the client in developing a plan for managing the emotional reactions (e.g., using calming

skills, positive self-talk, anxiety tolerance) generated by exposure to the scene of the traumatic event.

31. Go to the scene of the event with the client; offer support and encouragement to utilize the techniques identified in session to manage reactions.

32. Use exposure therapy methods with the client in conjunction with learned relaxation techniques to reduce stress reactions as they develop at the scene of the event.

17. Read books on forgiveness to gain a healthier perspective on the benefits of forgiveness. (33)

33. Recommend that the client read self-help books on forgiveness (e.g., *The Art of Forgiving* by Smedes or *Forgiveness Is a Choice: A Step-by-Step Process for Resolving Anger and Restoring Hope* by Enright); process material read.

18. Place responsibility for the trauma on the perpetrator without equivocation. (34)

34. Assign the client to write a letter to the perpetrator where responsibility for the traumatic event is placed on the perpetrator of the trauma; encourage the client to express his/her pain, anger, anxiety, and depression that have resulted from the trauma without taking on irrational, undue guilt; process the letter in session.

19. Participate in a survivor of trauma support group. (35)

35. Refer the client to a support group that is focused on the nature of the trauma that the client was exposed to; encourage the client to share his/her experience in the traumatic events and its effects with other survivors in the group.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.24 | F43.22 | Adjustment Disorder, With Anxiety |
| 309.28 | F43.23 | Adjustment Disorder, With Mixed Anxiety and Depressed Mood |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 300.21 | F40.00 | Agoraphobia |
| 300.01 | F41.0 | Panic Disorder |
| 301.6 | F60.7 | Dependent Personality Disorder |
| 301.50 | F60.4 | Histrionic Personality Disorder |
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# ANXIETY[1]

## BEHAVIORAL DEFINITIONS

1. Excessive and/or unrealistic worry about a number of events or activities that is difficult to control and is interfering with daily functioning.
2. Motor tension (e.g., restlessness, tiredness, shakiness, muscle tension).
3. Autonomic hyperactivity (e.g., palpitations, shortness of breath, dry mouth, trouble swallowing, nausea, diarrhea).
4. Hypervigilance (e.g., feeling constantly on edge, experiencing concentration difficulties, having trouble falling or staying asleep, exhibiting a general state of irritability).

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## LONG-TERM GOALS

1. Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired.
2. Stabilize anxiety level while regaining self confidence and a sense of serenity.

[1]Much of the content of this chapter (with only slight revisions) originates from A. E. Jongsma, Jr., L. M. Peterson, and T. J. Bruce, *The Complete Adult Psychotherapy Treatment Planner*, 4th ed. (Hoboken, NJ: John Wiley & Sons, 2006). Copyright © 2006 by A. E. Jongsma, Jr., L. M. Peterson, and T. J. Bruce. Reprinted with permission.

3. Enhance ability to effectively cope with the full variety of life's anxieties.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Describe current and past experiences with the worry and anxiety symptoms, complete with their impact on functioning and attempts to resolve it. (1, 2) | 1. Assess the focus, excessiveness, and uncontrollability of the client's worry and the type, frequency, intensity, and duration of his/her anxiety symptoms (e.g., Anxiety Disorders Interview Schedule for *DSM-5*: Client Interview Schedule).<br>2. Inquire if anxiety symptoms are consistent with a panic attack and/or anxiety attack; address accordingly. |
| 2. Complete psychological tests designed to assess worry and anxiety symptoms. (3) | 3. Administer a client-report measure to help assess the nature and degree of the client's worry and anxiety symptoms (e.g., Beck Anxiety Inventory; Penn State Worry Questionnaire; State-Trait Anxiety Inventory). |
| 3. Cooperate with an evaluation by a physician or psychiatrist for psychotropic medication. (4, 5, 6) | 4. Refer the client to a physician to identify and treat any medical conditions that may be contributing to anxiety (e.g., hypoglycemia, drug intoxication/withdrawal, parathyroid disease, etc.). |

5. Refer the client to a physician or psychiatrist for a psychotropic medication consultation.

6. Obtain a release of information to confer regularly with the prescribing physician or psychiatrist; monitor the client's psychotropic medication compliance, side effects, and effectiveness.

4. Verbalize an understanding of the cognitive, physiological, and behavioral components of anxiety and its treatment. (7, 8)

7. Discuss how generalized anxiety typically involves excessive worry about unrealistic threats, various bodily expressions of tension, overarousal, and hypervigilance, and avoidance of what is threatening that interact to maintain the problem (see *Mastery of Your Anxiety and Worry: Workbook,* 2nd ed. by Craske and Barlow).

8. Discuss how treatment targets worry, anxiety symptoms, and avoidance to help the client manage worry effectively and reduce overarousal and unnecessary avoidance.

5. Learn and implement calming skills to reduce overall anxiety and manage anxiety symptoms. (9, 10, 11, 12)

9. Teach the client relaxation skills (e.g., progressive muscle relaxation, slow diaphragmatic breathing, guided imagery, meditation) and how to discriminate better between relaxation and tension; teach the client how to apply these skills to his/her daily life (e.g., *New Directions in Progressive Relaxation Training: A Guidebook for Helping Professionals* by Bernstein and Borkovec; *Treating Generalized Anxiety Disorder: Evidenced-Based Strategies, Tools, and Techniques* by Rygh and

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| | Sanderson); review and reinforce success while providing corrective feedback toward improvement. |
| | 10. Utilize biofeedback techniques to facilitate the client's success at learning relaxation skills. |
| | 11. Develop and reinforce a routine of physical exercise for the client; recommend the client read and implement exercise programs (e.g., *Exercising Your Way to Better Mental Health* by Leith); process material read. |
| | 12. Assign the client to read relevant books on calming strategies or ways to reduce overall anxiety (e.g., *Mastery of Your Anxiety and Worry: Workbook,* 2nd ed. by Craske and Barlow; *When I Say No I Feel Guilty* by Smith); process material read. |
| 6. Verbalize an understanding of the role that cognitive biases play in excessive irrational worry and persistent anxiety symptoms. (13, 14) | 13. Discuss examples demonstrating that unrealistic worry typically overestimates the probability of threats and underestimates or overlooks the client's ability to manage realistic demands (or assign "Past Successful Anxiety Coping" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma). |
| | 14. Teach the client how to use an automatic thought record to identify and track cognitive biases about irrational worry and persistent anxiety symptoms; challenge the thoughts and assist him/her in replacing the cognitive biases with more realistic messages. |
| 7. Identify, challenge, and replace biased, fearful self-talk with | 15. Explore the client's schema and self-talk that mediate his/her fear |

positive, realistic, and empowering self-talk. (15, 16, 17)

response; challenge the biases; assist him/her in replacing the distorted messages with reality-based alternatives and positive self-talk that will increase his/her self-confidence in coping with irrational fears.

16. Teach the client how to use an automatic thought record (see *I Want to Change My Life: How to Overcome Anxiety, Depression and Addiction* by Melemis) to identify fearful self-talk and replace with positive, empowering self-talk; review and reinforce success, providing corrective feedback toward improvement.

17. Assign the client a homework exercise in which he/she journals times when anxiety responses are successfully managed between sessions and when he/she identifies fearful self-talk and creates reality-based alternatives (see "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); review and reinforce success, providing corrective feedback for failure.

8. Utilize exposure techniques to reduce the anxiety response. (18, 19)

18. Help the client gain insight into the notion that worry is a form of avoidance of a feared problem and that it creates chronic tension.

19. Ask the client to vividly imagine worst-case consequences or worries, holding them in mind until anxiety associated with them weakens (up to 30 minutes); generate reality-based alternatives to that worst case

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| | and process them (see *Mastery of Your Anxiety and Worry: Workbook,* 2nd ed. by Craske and Barlow). EBT |
| 9. Learn and implement problem-solving strategies for realistically addressing worries. (20) EBT | 20. Teach problem-solving strategies involving specifically defining a problem, generating options for addressing it, evaluating the pros and cons of the options, implementing a plan, reevaluating and refining the plan. EBT |
| 10. Learn and implement relapse prevention strategies for managing possible future anxiety symptoms. (21, 22, 23, 24) EBT | 21. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of worry, anxiety symptoms, or urges to avoid, and relapse with the decision to continue the fearful and avoidant patterns. EBT |
| | 22. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur. EBT |
| | 23. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, relaxation techniques, exposure, problem-solving strategies) as needed to address emergent worries, building them into his/her life as much as possible. EBT |
| | 24. Develop a *coping card* on which coping strategies and other important information (e.g., "Breathe deeply and relax," "Challenge unrealistic worries," "Use problem-solving," "Let the anxiety pass") are written for the client's later use. EBT |
| 11. Read books on overcoming anxiety. (25) EBT | 25. Assign the client to read self-help books or psycho-educational chapters of books on |

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| | overcoming anxiety (e.g., *Mastery of Your Anxiety and Worry: Workbook,* 2nd ed. by Craske and Barlow; *The Anxiety and Phobia Workbook,* 5th ed. by Bourne; *Living with Fear: Understanding and Coping with Anxiety* by Marks); review material read, reinforce success, or provide corrective feedback toward improvement. |
| 12. Utilize community resources to resolve daily living stressors that trigger anxiety. (26) | 26. Refer the client to local community resources (welfare department, housing programs, financial assistance resources, etc.) that can assist in resolving social stressors contributing to anxiety symptoms; review information obtained, monitor compliance. |
| 13. Complete a cost benefit analysis of maintaining the anxiety. (27) | 27. Ask the client to evaluate the cost and benefits of worries (e.g., complete the Cost Benefit Analysis exercise in *Ten Days to Self-Esteem* by Burns), in which he/she lists the advantages and disadvantages of the negative thought, fear, or anxiety; process the completed assignment. |
| 14. Avoid central nervous system stimulants in daily diet. (28) | 28. Educate the client on the importance of avoiding stimulants in his/her diet (e.g., caffeine, nicotine, over-the-counter medications, vitamins) because of their stimulation effect on the central nervous system; refer to a nutritionist, review and monitor compliance with recommendations as well as the client refraining from intake/use of stimulants. |
| 15. Utilize a paradoxical intervention technique to reduce the anxiety response. (29) | 29. Develop a paradoxical intervention (see *Ordeal Therapy* by Haley), in which the client is |

encouraged to have the problem (e.g., anxiety) and then schedule that anxiety to occur at specific intervals each day (at a time of day/night when the client would be clearly wanting to do something else) in a specific way and for a defined length of time.

16. Identify major life conflicts from the past and present that form the basis for present anxiety. (30, 31, 32)

30. Assist the client in becoming aware of key unresolved life conflicts and in starting to work toward their resolution.

31. Reinforce the client's insight into the role of his/her past emotional pain and present anxiety.

32. Ask the client to develop and process a list of key past and present life conflicts that continue to cause worry.

17. Provide honest and complete information for a chemical dependence biopsychosocial history, including use of any substances that may be contributing to anxiety symptoms. (33, 34, 35)

33. Assess the client for the presence of chemical dependence; including use of marijuana, over-the-counter medications, and herbal remedies used to self-medicate symptoms of anxiety.

34. Use the biopsychosocial history to help the client understand the familial, emotional, and social factors that contributed to the development of chemical dependence.

35. Refer the client for treatment for chemical dependence and/or 12-step group to establish and maintain sobriety.

18. Maintain involvement in work, family, school, and social activities. (36, 37)

36. Support the client in following through with work, family, school, and social activities rather than escaping or avoiding them to focus on anxiety symptoms.

37. Ask the client to list several ways his/her life will be more satisfying or fulfilling as he/she manages his/her symptoms of anxiety and continues normal responsibilities; review and provide corrective feedback for success.

19. Attend a coping with anxiety support group. (38)

38. Refer the client to a support group for people who suffer from anxiety; encourage the client to share how their anxiety manifests to help others and learn ways to cope better with their anxiety by listening to others.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 309.24 | F43.22 | Adjustment Disorder, With Anxiety |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 300.00 | F41.9 | Unspecified Anxiety Disorder |
| 308.3 | F43.0 | Acute Stress Disorder |
| 300.21 | F40.00 | Agoraphobia |
| 300.01 | F41.0 | Panic Disorder |
| 300.23 | F40.10 | Social Anxiety Disorder (Social Phobia) |
| 300.29 | F40.xxx | Specific Phobia |
| 301.82 | F60.6 | Avoidant Personality Disorder |
| 301.83 | F60.3 | Borderline Personality Disorder |
| 301.50 | F60.4 | Histrionic Personality Disorder |
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# BULLYING VICTIM

## BEHAVIORAL DEFINITIONS

1. Has been subjected to repeated and direct physically, emotionally, or socially abusive acts in an intentional effort to harm, humiliate, or intimidate.
2. Has been subjected to indirect bullying including deliberate exclusion; name calling; intimidation or misuse of power; manipulation; spreading rumors; use of threatening words, gestures, or looks.
3. Manifests social insecurity, social withdrawal, increased isolation, hopelessness, defenselessness, loss of dignity.
4. Describes feelings of terror, persecution, intimidation, or paranoia (especially associated with specific settings such as school or work).
5. Displays evidence of decreased self-esteem, depression, cries easily, suicidal/homicidal ideations, increased somatic complaints, changes in eating/sleeping patterns.
6. Verbalizes feeling picked on, persecuted, rejected, intimidated, alone, threatened, and a decreased sense of trust.
7. Possessions have been found damaged, missing, or "lost."
8. Carries or attempts to carry weapons for protection (gun, knife, etc.).
9. Displays "victim" body language of hunched shoulders, hanging head, avoiding eye contact, lack of smile.
10. Academic performance has deteriorated due to increased absences and lack of concentration.
11. Reports cyberbullying to occur through email, instant messaging, chat rooms, website or gaming sites, digital messages or images sent to a cellular communication device.
12. Verbalizes feelings of anger and rage directed toward those who are abusive or not accepting.

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## LONG-TERM GOALS

1. Take legal steps necessary to guarantee safety and establish a plan of escape from the bully.
2. Return to the level of functioning present before the bullying began.
3. Receive the psychologgical and social support necessary to recover from the effects of being bullied, reducing the risks of long-term psychological distress.
4. Overcome the fear of harm and intimidation by increasing assertive personality characteristics.

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## SHORT-TERM OBJECTIVES

1. Describe the history, nature, and intensity of the bullying as well as reaction to it. (1, 2, 3)

## THERAPEUTIC INTERVENTIONS

1. Gather a history of the bullying, determining when the bullying began, individuals involved in the acts of bullying, and the impact of the bullying upon emotional state as well as personal, social, vocational, or academic functioning.
2. Ask the client to write a list of specific incidents of bullying including dates, times, situations, and people; encourage the client to keep a diary or journal of incidents of bullying if it continues to occur.

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| | 3. Review with the client his/her history of peer relationships, identifying people or situations where the client felt vulnerable to bullying. |
| 2. Describe emotional reactions experienced since the bullying started and how daily functioning has been impacted. (4, 5, 6, 7) | 4. Have client complete a screening instrument to determine the severity with which symptoms from bullying are occurring (e.g., Trauma Symptom Inventory–2). |
| | 5. Discuss how bullying has resulted in changes in the client's activities of daily living to avoid confrontation, humiliation, or harm from the bully; process feelings of emotional and physical vulnerability. |
| | 6. Identify what actions the client has already taken to address the bullying (who at school or work has the client spoken to, attempts to talk with the bully, items of protection being carried, etc.). Explore if the client feels isolation and/or feels like he/she doesn't "fit in" socially; process reactions. |
| | 7. Assess if implied or stated harm to the client's home, family members, friends, or support systems has occurred; assess realistic level of harm to others, taking the necessary advisory precautions as indicated and identifying ways that safety for all concerned can be addressed. |
| 3. Verbalize symptoms of anxiety or depression, including any suicidal ideation. (8, 9) | 8. Administer to the client a self-report measure (e.g., Beck Depression Inventory–II or General Anxiety Disorder–7 [GAD-7]) to assess the depth of depression and/or anxiety symptoms and suicide risk; evaluate the results and give feedback to the client. |

9. Assess and monitor the client's suicide potential; arrange for psychiatric hospitalization, as necessary, when the client is determined to be harmful to self.

4. Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk. (10, 11, 12)

10. Assign the client a homework exercise in which he/she journals times when emotional distress is successfully managed between sessions and when he/she identifies fearful self-talk and creates reality-based alternatives (see the exercise "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); review and reinforce success, providing corrective feedback for failure.

11. Educate the client regarding how to use an automatic thought record to identify and track fearful self-talk; challenge and replace self-talk that triggers fear with positive, empowering cognitive messages that will increase self-esteem, self-confidence, and facilitate a reduction in fear, worry, or anxiety responses.

12. Teach the client a guided self-dialogue procedure in which he/she learns to recognize maladaptive self-talk, challenge its biases, cope with engendered feelings, overcome avoidance, and reinforce his/her accomplishments; review and reinforce progress; and problem-solve obstacles.

5. Utilize behavioral strategies to reduce cognitive, emotional, and/or behavioral stress reactions. (13, 14, 15)

13. Explore the reduction of distress by the client participating in constructive social activities that involve physical engagement (e.g.,

recreational sports, volunteer opportunities, community events); reinforce the client's engagement in the activities to develop relationships with others of similar interests where his/her self-confidence in using positive social skills can be reinforced.

14. Assist the client in developing behavioral coping strategies (e.g., increased social involvement, maintain a journal, improved sleep, eat a balanced diet, avoid use of alcohol or drugs, reduce caffeine or nicotine intake, take part in massage therapy, establish an exercise routine) for reducing feelings of depression and anxiety; reinforce success in session.
15. Develop a "coping card" on which coping strategies and other important information are written for the client's later use (e.g., "You're safe," "Pace your breathing," "Believe in yourself," "You can manage this," "Let the fear pass," and "Call a support person").

6. Learn and implement assertiveness techniques to manage bullying situations with increased self-confidence. (16, 17, 18)

16. Teach and role-play with the client assertive communication skills (e.g., see *How to Express Your Ideas and Stand Up for Yourself at Work and in Relationships* by Peterson); encourage use of the skills in everyday living situations as well as situations of intimidation.
17. Teach the client assertiveness techniques (e.g., eye contact, posture, personal space, active listening, *I* messages, broken record, etc.) to be used with confidence when approached by the bully in a public domain;

reflect on feelings of confidence versus helplessness when using assertiveness.

18. Refer the client to self-defense classes, Tae Bo, or karate classes to increase a sense of mastery and self-confidence and decrease feelings of vulnerability.

7. Identify if cyberbullying is occurring and implement problem-solving strategies to eliminate cyberbullying. (19, 20)

19. Discourage the client from participating in or responding to cyberbullying material, discussions, or gossip/rumors posted online. Access with the client digital mediums where the client has been bullied; report incidents of cyberbullying to site webmasters and print off digital material received on communication devices for evidence of cyberbullying occurring.

20. Ask family/friends to support the client being targeted by cyberbullying by sending the client positive, affirming electronic messages, imposing parental controls/monitoring on social networking sites.

8. Identify individuals that will offer physical and emotional support in times of distress. (21, 22)

21. Encourage the client to communicate daily with support systems (e.g., school staff, employee assistance program staff, friends, family members) until the bullying ceases; discuss ways to verbally and nonverbally communicate with support systems (e.g., use of hand signals or body language) to advise support systems if bullying is occurring; monitor the client's compliance in daily communication.

22. Offer a family or group therapy session to have the client communicate to his/her family or

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| | friends the bullying situation he/she is in; educate family/friends on ways they can help protect the client as well as when to contact law enforcement or school personnel. |
| 9. Identify, challenge, and replace self-blame with an understanding that the bullying is the responsibility of the bully. (23, 24, 25, 26) | 23. Assess if the client believes he/she is to blame for the bullying; confront and challenge any of the client's minimizing or making excuses regarding the seriousness of the bullying. |
| | 24. When the client expresses guilt/self-blame, redirect the client to view the bullying as an action committed against him/her for which the bully is responsible; help the client regain a feeling of self-control by recognizing bullying is occurring and affirming the client is not the cause of it. |
| | 25. Identify positive actions and comments the client made/did in response to bullying and what positive outcomes developed as a result of his/her actions; reinforce the client's use of positive statements regarding confidence and assertiveness. |
| | 26. Assign the client a homework exercise in which he/she identifies self-blaming messages triggered by the bullying and then creates reality-based, perpetrator-blaming alternatives; review and reinforce success in sessions, providing corrective feedback for failure. |
| 10. Learn and implement problem-solving strategies for realistically addressing worries. (27, 28) | 27. Teach the client problem-solving strategies specifically defining a problem, generating options for addressing it, evaluating the pros and cons of each option, |

implementing a plan, and reevaluating and refining the plan.

28. Assign the client a homework exercise in which he/she problem-solves a current problem (see *Mastery of Your Anxiety and Worry: Workbook,* 2nd ed. by Craske and Barlow); review, reinforce success, and provide corrective feedback toward improvement.

11. Develop a safety plan for protection from ongoing bullying. (29)

29. Assist the client in developing a written safety plan that details what actions will be taken to establish and maintain physical and emotional safety (e.g., filing a restraining order, using alternate routes, cooperating with school officials or law enforcement, not to react to bullying but walk away toward a support person for help, etc.).

12. Cooperate with school, law enforcement, or work authorities in their investigation. (30)

30. Encourage the client to file a school, police, or work report about bullying or harassment and to work collaboratively with authorities; confront any resistance such as fear of disclosing, feelings of hopelessness, and so forth, by reminding the client of the need to establish and maintain his/her safety.

13. Change daily routines to decrease likelihood of the bully having contact with the client. (31, 32)

31. Assign the client to complete a time study of his/her daily actions, activities, or attendance in activities/associations/groups for a week. Review in session, assessing for options in alterations to his/her routine schedules (e.g., leaving/arriving home at different times, attending activities at a different time, change class schedule); monitor the client's compliance in using the alternative routines.

32. Assist the client in identifying alternative routes to school, work, and other activities; encourage him/her to use these alternative routes to decrease the likelihood of contact with the bully; monitor the client's compliance in using the alternative routes.

14. Maintain involvement in social, academic, and vocational activities without distress. (33)

33. Encourage the client to return to work, school, social engagements, and/or daily routines that occurred prior to the start of bullying; phase these activities into daily living gradually, but steadily, if necessary.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 296.2x | F32.x | Major Depressive Disorder, Single Episode |
| 296.3x | F33.x | Major Depressive Disorder, Recurrent Episode |
| V61.10 | Z63.0 | Relationship Distress with Spouse or Intimate Partner |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 301.0 | F60.0 | Paranoid Personality Disorder |
| 301.83 | F60.3 | Borderline Personality Disorder |
| 301.6 | F60.7 | Dependent Personality Disorder |
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# CHILD ABUSE / NEGLECT

## BEHAVIORAL DEFINITIONS

1. Wounds, bruises, and so on, in different stages of healing that provide evidence of ongoing physical abuse.
2. Medical documentation of failure to thrive in infants (weight below the fifth percentile for age) or brain trauma secondary to violent shaking.
3. Caretaker fails to provide basic shelter, food, supervision, medical care, or support.
4. Blood in underwear/genital region, sexually transmitted diseases, or tears in the vagina or anus, which provide evidence of sexual abuse.
5. Report by self, parents, law enforcement, medical professionals, educators, and/or Children's Protective Services of intentional harm or a threat of harm by someone acting in the role of caretaker.
6. Repetitive play that reenacts situations regarding the abuse.
7. Coercive, demeaning, or overly distant behavior by a parent or other caretaker that interferes with normal social or psychological development.
8. Inappropriate exposure, directed by an older person, to sexual acts or material (e.g., printed images, computer images, video content).
9. Age-inappropriate knowledge and/or interest in sexual behavior.
10. Pronounced change in mood and/or affect (e.g., depression, anxiety, irritability).
11. Behaviors that is incongruent with chronological age such as thumb sucking, bed wetting, clinging to the parent, and so on.
12. Nightmares, difficulty falling asleep.
13. Recurrent and intrusive recollections of the abuse.
14. Avoidance of situations related to the abuse; demonstrating fear when around the suspected abuser.
15. Explosive reactions of rage, anger, and/or aggression when exposed to the abuser or situations that trigger memories of the abuse.

16. Withdrawal from activities with peers, family, and school that were previously a source of pleasure.

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## LONG-TERM GOALS

1. Establish and maintain safety of the child.
2. Develop the skills necessary to maintain appropriate boundaries within the family.
3. Return to the level of psychological, emotional, social, and educational functioning present before the abuse began.
4. Assimilate the abuse into daily life experiences without ongoing distress or regression.
5. Prevent the cycle of abuse from occurring with peers, spouses, the client's own children, and so on.

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## SHORT-TERM OBJECTIVES

1. Describe the nature, frequency, and intensity of the abuse. (1, 2, 3, 4)

## THERAPEUTIC INTERVENTIONS

1. Actively develop rapport with the child by providing reassurance, compassion, and trust; use age-appropriate terminology and interview strategies (e.g., sitting on the floor, use of toys, etc.) to establish rapport.

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| | 2. Obtain a release of information from the parents or guardian of the child to appropriate agencies/ individuals (Children's Protective Services, law enforcement, health care professionals, school personnel, relatives) and consult with those who have factual details of the abuse to corroborate and/or elaborate on the child's recall of abuse. |
| | 3. Coordinate a child abuse assessment (description of the abuse, when/where the abuse occurred, the impact of the abuse upon personal, social, family, and educational activities) in collaboration with law enforcement or Children's Protective Services to prevent further traumatization and/or manufactured memories caused by multiple inquiries about the abuse. |
| | 4. Establish rapport with the child with a parent present and then meet with the child alone to further assess the abuse allegation and allow expression by the child without parental influence. |
| 2. Cooperate with a medical assessment and evidence collection related to abuse or neglect. (5, 6) | 5. Assist in getting the child to his/her pediatrician, urgent care, or emergency department for a medical evaluation. |
| | 6. Refer the child to a pediatrician trained in child sexual abuse evaluation for evidence collection and evaluation of any injuries; monitor the caregiver's compliance with the assessment and treatment recommendations. |
| 3. Cooperate with a safety plan for protection from ongoing abuse; | 7. Develop a written safety plan that details what actions will be |

cooperate with authorities in their investigation. (7, 8, 9, 10)

taken to establish and maintain physical and emotional safety for the child (e.g., filing a report to Children's Protective Services or other law enforcement agencies, being placed in temporary protective custody, respecting privacy, stopping any overt sexual behavior in front of child, etc.).

8. Discuss with child's family/support systems who would be willing and able to provide a safe, protected living situation; encourage the client to move in with those individuals until safety is established; monitor compliance and progress.
9. Encourage the child to work collaboratively with the law enforcement or protective services investigation; confront any resistance such as fear of retaliation, feelings of hopelessness or helplessness, and the like, by reminding the client of the need to establish and maintain her/his safety.
10. Inquire, if either implied or directly stated, whether other children or family members in the home have been threatened harm from the abuser; assess realistic level of harm to others advising those affected by the threat and identifying ways safety for all concern can be addressed.

4. Describe the feelings that were experienced at the time of the abuse and how daily functioning has been impacted. (11, 12, 13, 14)

11. Actively build a level of trust with the child through consistent eye contact, unconditional positive regard, use of play therapy techniques (see *101 Favorite Play Therapy*

*Techniques* by Kaduson and Schaefer) to assist the child in expressing emotional reactions (fear, betrayal, rage, etc.) to the abuse; process reactions.

12. Assess the child's frequency, intensity, and duration of traumatic reactions on his/her emotional, cognitive, and behavioral functioning (e.g., using an objective instrument such as Trauma Symptom Checklist for Children; Childhood Trauma Questionnaire; Reynolds Child Depression Scale; Child Behavior Checklist).
13. Obtain a release of information from the parents or guardian to allow contact with school or child care personnel to ascertain if there has been a change in the child's behavior or mood consistent with the timing of when the abuse was reported to have begun.
14. Develop with the child a symptom development time line to identify how the abuse has negatively impacted his/her life through avoidance of abuser confrontation due to fear of reoccurrence of the abuse.

5. Identify and replace cognitive messages that promote fear, worry, or anxiety. (15, 16, 17)

15. Discuss facts of the abuse to explore the child's possible distorted cognitive messages that intensify the negative emotional reactions to the abuse.
16. Help the child develop reality-based cognitive messages that will enhance self-confidence, increase adaptive actions, and facilitate a reduction in fear, worrying, or anxiety responses.

17. Teach the child how to use expressive arts techniques (drawing, painting, collage, sculpting) to identify and track distorted cognitions about the abuse; assist him/her in replacing the cognitive distortions related to the abuse with more realistic messages.

6. Identify, challenge, and replace self-blame by placing responsibility for the abuse on the perpetrator. (18, 19, 20)

18. Assess if the child believes he/she is to blame for the abuse; confront and challenge any of the child's self-talk where he/she expresses blame for the abuse; create reality-based alternative thoughts (the abuse as a violation committed against her/him that happened beyond his/her control, placing the blame on the perpetrator). Review and reinforce success in sessions, providing corrective feedback for failure.

19. Confront and challenge any of the child's (or parents') minimizing or making excuses regarding the seriousness of the abuse.

20. Assign the child to write a letter to the perpetrator where responsibility for the abuse is placed on the perpetrator; encourage the child to express his/her shame, anger, helplessness, fear, and depression that have resulted from the abuse without taking on irrational, undue guilt. Process the letter in a session.

7. Learn and implement a thought-stopping technique to manage intrusive unwanted thoughts. (21, 22)

21. Explore whether the child is having any flashback experiences to abuse; assign a homework exercise of drawing or writing recurring images or memories

associated with the abuse; process in session.

22. Teach the child to implement a thought-stopping technique (thinking of a stop sign, yelling *STOP* only in the mind, and then imagining a pleasant scene) immediately upon experiencing unwanted thoughts; monitor and encourage the child's use of the technique in daily life between sessions (or assign the child and parents to work together on the "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

8. Learn and implement relaxation techniques to reduce cognitive, emotional, and/or behavioral stress reactions. (23, 24, 25)

23. Teach the child relaxation techniques (e.g., deep breathing exercises, progressive muscle relaxation, yoga, binaural sounds, visualization techniques) and how to apply these skills to his/her daily life.

24. Have the child describe in graphic detail memories of the abuse (e.g., sounds, sights, smells, emotions, touch/physical contact, etc.), beginning with the least anxiety-provoking memories; implement a desensitizing exposure procedure for reducing the symptoms; reinforce success or provide corrective feedback toward improvement.

25. Monitor the child for signs and symptoms of acute and/or post-traumatic stress disorder; treat accordingly (see Posttraumatic Stress Disorder and/or Acute Stress Disorder chapters of this *Planner*).

9. Implement behavioral strategies to reduce emotional distress. (26)

26. Assist the child in developing coping strategies (e.g., journaling, drawing, getting enough sleep, applied relaxation, exercise, balanced diet, engaging in counseling) for reducing emotional distress; reinforce success.

10. Maintain involvement in social and educational activities without demonstrating inappropriate sexual or aggressive behaviors. (27, 28)

27. Teach the child about good touches and bad touches (see *Good Touch, Bad Touch: Learning About Proper and Improper Touches* by Connor) and how to interact with peers without aggression or display of sexual behaviors; use role-playing to demonstrate appropriate social interactions.

28. Review with the child his/her history of peer and family relationship, identifying situations where the child felt vulnerable.

11. Identify individuals that will offer physical and emotional support in times of distress. (29, 30)

29. Engage the child in drawing an eco-map to identify people whom the child can rely upon for support; review the eco-map, encouraging the child to have frequent communication with supportive people; review progress in session, addressing resistance or noncompliance.

30. Encourage the child to communicate daily with his/her support systems to reduce feelings of insecurity, fear, or anxiety; monitor the client's compliance in daily communication.

12. Participate in a support group for children who have been abused. (31)

31. Refer the child to a support group that is focused on children who have been through similar abusive experiences; encourage the child to share the experience

and its effects with others in the group.

13. Parents learn and implement conflict resolution skills to effectively discipline their child. (32, 33, 34, 35)

32. Refer the parents to treatment focused on developing skills necessary to establish and maintain safety of the child and use of appropriate discipline methods (e.g., parentinginformed .com, Parents Anonymous, Parenting class.net, *Discipline With Love and Logic* by Cline and Fay); monitor the parent's compliance in attendance, confront absences or resistance to attend; notify Children's Protective Services of noncompliance as needed.

33. Educate and role-play with the parents nonviolent discipline methods (e.g., use of time-outs, removing privileges, use of *1-2-3 Magic: Effective Discipline for Children 2–12* by Phelan and use of immediate and reasonable consequences for undesired behaviors); reinforce success.

34. Recommend the parents read self-help books on effective disciplining (*1-2-3 Magic: Effective Discipline for Children 2–12* by Phelan*, Parenting With Love and Logic* by Cline and Fay, *Making Children Mind Without Losing Yours* by Leman); process material read.

35. In conjoint sessions, educate parents on effective anger management techniques (walking away, taking a deep breath, counting to 10, hugs versus hits philosophy, respectful communication, assertiveness without aggression, compromise) to reinforce effective discipline

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| | practices; use modeling, role-playing, and behavior rehearsal toward improvement. |
| 14. Parents learn and implement effective problem-solving strategies for realistically addressing psychosocial stressors. (36, 37) | 36. Teach problem-solving strategies involving specific social stressors (limited finances, isolation, lacking basic needs); generate options for addressing the problem, evaluating the pros and cons of the options, selecting and implementing an action plan, and reevaluating and refining the plan.<br>37. Refer the parents to the local welfare department to identify community resources (housing programs, AFDC, WIC, etc.) that can assist in resolving social stressors; review information obtained; monitor compliance. |
| 15. Parents verbalize an understanding of the relationship between their abusive childhood experiences and their current abusive actions. (38, 39) | 38. Engage the parents in drawing a genogram to identify relationships in their past that contained emotional, verbal, physical, sexual abuse, and/or incest; discuss how this has contributed to perpetrating abuse against their own child.<br>39. Explore experiences from the parent's childhood that taught him/her to excuse abusive behavior; teach appropriate limits and boundaries for behavior. |
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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.2x | Adjustment Disorder |
| 995.52 | T74.02XA | Child Neglect, Confirmed, Initial Encounter |
| 995.52 | T74.02XD | Child Neglect, Confirmed, Subsequent Encounter |
| 995.53 | T74.22XA | Child Sexual Abuse, Confirmed, Initial Encounter |
| 995.53 | T74.22XD | Child Sexual Abuse, Confirmed, Subsequent Encounter |
| 307.47 | F51.5 | Nightmare Disorder |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
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# CRIME VICTIM TRAUMA

## BEHAVIORAL DEFINITIONS

1. Exposure to a crime that involved the death of someone else, actual or threatened death or serious injury or loss to self (e.g., kidnapping, carjacking, home invasion/burglary, sexual assault), or workplace crisis (e.g., robbery, hostage, bomb threat).
2. Sudden death of student while participating in or attending a school-supported activity such as an athletic or social event.
3. Recurrent, intrusive, traumatic memories, flashbacks, and nightmares related to crime.
4. Preoccupation or disclosure of suicidal or homicidal ideations following the crime.
5. Difficulty in concentrating and following directions following the crime.
6. Increased use of alcohol or other mood-altering substances following the crime.
7. Persistent fear of death or personal injury occurring to self.
8. Experiencing suspiciousness and mistrust of others following the crime to the point that it interferes with daily functioning.
9. Social withdrawal and isolation; avoidance of certain locations.
10. Inability to regulate emotions following the crime.
11. Feelings of guilt regarding having survived a crime in which others died.
12. Disruption of typical sleep patterns following the crime.
13. Physical symptoms such as chest pain, chest pressure, sweats, shortness of breath, muscle tension, headaches, intestinal upset, heart palpitations, and dry mouth.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore appropriate levels of emotional, behavioral, and cognitive functioning.
3. Reduce physical complaints.
4. Reestablish a sense of meaning for the future.
5. Return of a sense of safety to self and family.
6. Reestablish healthy and appropriate relationships.

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## SHORT-TERM OBJECTIVES

1. Secure medical care for any injury resulting from the incident. (1, 2)

2. File a report with law enforcement. (3)

3. Explore perceptions of the traumatic incident. (4)

## THERAPEUTIC INTERVENTIONS

1. Assist the client in receiving immediate medical attention from Emergency Medical Personnel, Urgent Care facility, or Emergency Room.
2. Refer the client to a physician for medical evaluation and treatment.
3. Refer and assist, if needed, the client to local law enforcement agency to file a report of the incident.
4. Assure the client of his/her safety and use active listening skills to explore affective, behavioral, and cognitive reactions while he/she discusses the crime in as much detail as he/she is comfortable with (or assign "Share the Painful Memory" in the *Adult*

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| | *Psychotherapy Homework Planner*, 2nd ed. by Jongsma). |
| 4. Share facts, thoughts, and feelings about the crime with trusted family members and friends. (5, 6, 7) | 5. Help the client identify trusted family members and friends with whom the crime experience can be shared.<br>6. Encourage and facilitate the client sharing affective, behavioral, and cognitive reactions with a professional therapist, family member, and/or trusted friend.<br>7. Role-play with the client, disclosing information about the crime to different people in the community; process the reactions to the exercise. |
| 5. Report confidence in personal actions taken during the incident rather than second-guessing these. (8, 9) | 8. Explore the clients' feelings and thoughts that he/she experienced before and during the crime; reassure him/her of the typical automatic behavioral and emotional responses that occur in these crisis situations.<br>9. Redirect the client's negative evaluation to a realistic, non-judgmental evaluation of his/her behavior by focusing on the facts of what took place during the crime and his/her understandable response. |
| 6. Decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the event. (10) | 10. Assess the client for increased use of alcohol and other mood-altering substances following the event that are used as a means of coping with the trauma; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary. |
| EBP 7. Learn and implement calming and coping strategies to manage | 11. Teach the client strategies from stress inoculation training such |

the anxious reactions to the crime. (11)

8. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk about the crime. (12, 13)

9. Participate in imaginal and *in vivo* exposure to crime-related memories until thinking about the trauma does not result in marked distress. (14, 15, 16)

as relaxation and breathing control to manage unrealistic fears regarding the crime.

12. Explore the client's schema and self-talk that causes incident-related fears; challenge negative biases and assist him/her in generating appraisals that correct for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

13. Assign the client homework exercises (e.g., journaling or writing and reviewing flash cards with positive self-talk) in which he/she identifies fearful self-talk about the crime and creates reality-based alternatives; review and reinforce success, providing corrective feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

14. Direct and assist the client in constructing a fear and avoidance hierarchy of trauma-related stimuli.

15. Assign the client homework exercises in which he/she engages in exposure exercises to stimuli that evoke reactions similar to that experienced during the crime and records responses (see "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

16. Reduce anxiety regarding the crime by having the client use

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| | imaginal exposure to the trauma through describing the crime at an increasing but client-chosen level of detail; repeat until associated anxiety stabilizes; review and reinforce progress, problem solve obstacles. EBP |
| EBP 10. Develop healthy communication skills when discussing the crime with family members. (17, 18) | 17. Teach family members healthy communication skills (e.g., reflective listening, eye contact, respect, etc.) to be used when discussing the crime. EBP |
| | 18. Use cognitive behavior techniques (modeling, role-playing, corrective feedback, and positive reinforcement) to teach the family communication skills including assertive communication, offering positive feedback, active listening, making positive request of others for behavior change, and giving negative feedback in an honest and respectful manner. EBP |
| 11. Attend a self-help group offered by the community. (19) | 19. Direct the client to community-based and online self-help groups as well as volunteer opportunities (e.g., Crime Stopper, Block Watch, community resources such as Victims of Violent Crime Agency). |
| 12. Return to typical daily routines in a timely manner. (20, 21, 22) | 20. Educate the client about the importance of maintaining adequate eating and personal hygiene habits and help him/her plan ways to accomplish this. |
| | 21. Inquire about the client's sleeping patterns and suggest strategies to help him/her fall asleep (e.g., journaling, relaxation techniques). |

22. Assist the client in resuming pleasurable, routine daily activities.

13. Verbalize a resolution of irrational guilt feelings related to the crime. (23, 24)

23. Explore the client's regrets by asking about what he/she believes could have, should have, or would have been done.

24. Dispute the client's unreasonable sense of guilt over the crime, exploring and replacing irrational thoughts with realistic thoughts.

14. Maintain focus on the present rather than the crime of the past. (25, 26)

25. Acknowledge the desire for answers, but redirect the client from focusing on *why* questions to identify the affect behind the questions.

26. Discuss client's perception of threat and focus on claiming awareness of the present and maintaining sense of safety.

15. Implement a plan of constructively reacting to the economic consequences of the crime. (27, 28, 29)

27. Inquire regarding the economic impact of the crime on the client's finances (e.g., loss of income, paying bills, mortgage, and so on).

28. Assist the client in identifying sources of economic support (e.g., life insurance, family and friends, government victim programs, and so on).

29. Ask the client to write a plan of ways to meet economic needs (e.g., contacting creditors to ask for extension to pay bills); review the plan with the client.

16. Identify and implement previously used healthy stress management strategies to reduce current affective distress. (30)

30. Explore the client's history of experiencing other traumatic events and determine healthy coping mechanisms used at that time; encourage the use of those strategies with the current incident.

17. Identify positive consequences that may have resulted from the crime. (31)

18. Agree to access mental health services if grieving interferes with daily functioning. (32, 33, 34)

19. Cooperate with completing objective assessment instruments to determine the presence or absence of an ongoing dysfunctional reaction to the trauma. (35, 36)

31. Use reframing with the client to explore and identify positive changes (e.g., closer family relationships, increased appreciation of future) associated with positive recovery and resiliency following the crime.

32. Educate the client about possible flashbacks, depression, suicidal ideations, and other complications about the crime experience that would require additional intervention.

33. Provide the client with a list of available mental health referral resources.

34. Provide the client with pamphlets and other literature regarding recovery from crises and traumatic events.

35. Administer to the client assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Symptom Checklist–90–Revised, Trauma Symptom Checklist or guide treatment) to monitor the recovery process.

36. Conduct suicide and homicide assessments of the client as needed.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| V62.82 | Z63.4 | Uncomplicated |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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# CRITICAL INCIDENTS WITH EMERGENCY SERVICE PROVIDERS (ESPs)

## BEHAVIORAL DEFINITIONS

1. Serious injury or death of a coworker in the line of duty.
2. Suicide or unexpected death of a coworker.
3. Serious or unexpected death of a civilian as a result of emergency service activity.
4. Death of a patient following prolonged rescue attempts/heroic efforts.
5. Multiple fatalities or a mass-casualty incident.
6. Shooting of a subject, suicide of a subject in custody (e.g., hanging in jail/prison), or use of deadly force.
7. Inability to regulate emotions after providing emergency service services.
8. Reactions of shock, disbelief, confusion, helplessness, loss of control, and/or survivor's guilt causing irritability, anxiety, despair, fear, and/or anger following the provision of emergency service activities.
9. Change in health such as experiencing of headaches, nausea, shaking/tremors, fatigue, intestinal upset, diarrhea, and/or increased blood pressure.
10. Disruption to typical sleep patterns, normal appetite, and other daily, routine activities.
11. Increased tension in families causing marital discord, domestic violence, and/or child abuse.
12. Significant increase in and prolonged use of alcohol or other mood-altering substances following the provision of emergency services.
13. Reexperiencing the incident in thoughts, dreams, flashbacks, or recurrent images.
14. Experience of depersonalization, impaired memory, and/or short attention span following the provision of emergency services.
15. Decrease in morale resulting in withdrawal from normal routine work responsibilities and activities.
16. Decrease in confidence regarding decision-making skills.
17. Resistance to communication or excessive use of "black" humor.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore appropriate levels of emotional, behavioral, and cognitive functioning.
3. Reduce physical complaints.
4. Reestablish a sense of meaning for the future.
5. Return of a sense of safety to self and coworkers.
6. Regain confidence in ability to perform job duties.

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## SHORT-TERM OBJECTIVES

1. Cooperate with completing objective assessment instruments to determine the presence or absence of dysfunctional reactions to the trauma. (1)

## THERAPEUTIC INTERVENTIONS

1. To guide intervention that is needed, assess the ESP's affective, behavioral, and cognitive reactions to the incident through the use of instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Symptom Checklist–90–Revised, Trauma Symptom Checklist, Traumatic Life Events Questionnaire, Trauma Symptom Inventory-2, Beck Depression Inventory–II).

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| 2. Explore and verbalize perceptions of the incident. (2, 3) | 2. Reassure ESPs of their safety and use active listening skills to explore their affective, behavioral, and cognitive reactions while they recount the trauma in as much detail as they are comfortable with (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).<br>3. Encourage and facilitate the ESP in sharing affective and cognitive reactions with a professional therapist, family member, and/or trusted friend. |
| 3. Identify any physical injury or symptoms that resulted from the incident. (4) | 4. Inquire as to the medical care that has been received and refer the ESP to a physician as appropriate. |
| 4. Report confidence in actions taken during the incident rather than second-guessing these. (5, 6) | 5. Ask the ESP to share his/her thought process before and during the incident that led to his/her actions; reassure him/her of the automatic response that comes with being well trained.<br>6. Confront the ESP when he/she negatively evaluates his/her performance during the incident and redirect him/her toward a realistic, nonjudgmental perspective by focusing on the facts of what took place and his/her reasonable and professional response. |
| 5. Decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the event. (7) | 7. Assess the ESP for increased use of alcohol and other mood-altering substances following the event that are used as a means of coping with the trauma; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary. |

6. Implement calming and coping strategies to manage the reactions to the incident. (8)

8. Teach the ESP relaxation, breathing control, covert modeling (i.e., imagining the successful use of the strategy), and/or role-playing (i.e., with a therapist or trusted friend) from stress inoculation to manage fears until a sense of mastery is evident.

7. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (9, 10)

9. Explore incident-related fears using the ESP's schema and self-talk; challenge negative biases and assist him/her in generating appraisals that correct for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

10. Assign the ESP a homework exercise (e.g., listing fearful self-talk and creating note cards with reality-based alternatives); review and reinforce success, providing corrective feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

8. Discuss feelings and perceptions of the event with peers. (11, 12)

11. Refer the ESP to group therapy for trauma victims (preferably other ESPs) to talk among themselves regarding the traumatic incident; this may be a structured group (e.g., psychological debriefing group) or a process group.

12. Refer the ESP to an unstructured ESP self-help group focusing on recovery from a traumatic incident.

9. Prevent isolation and withdrawal through interaction with friends, family, and peers. (13, 14)

13. Assist the ESP in making arrangements for social opportunities (e.g., luncheons) as appropriate to interact with other ESPs.

14. Aid ESP in contacting trusted family members, friends, and/or other social systems that can be used for support during recovery.

10. Identify healthy stress management strategies used previously that can be implemented currently to reduce affective distress. (15)

15. Explore the ESP's history of experiencing other traumatic events and determine healthy coping mechanisms used at that time; encourage the use of those strategies with the current incident.

11. Identify healthy and constructive consequences that may have resulted from the traumatic event. (16)

16. Use reframing to explore and identify healthy, constructive changes (e.g., closer family relationships, increased appreciation of future) associated with positive recovery and resiliency following an incident.

12. Implement relapse prevention strategies for managing future trauma-related reactions. (17, 18)

17. Identify future situations or circumstances in which relapse could occur and rehearse with the ESP the management of these trigger situations.

18. Develop a "coping card" on which coping strategies and other important information (e.g., "pace yourself," "you can manage," "breathe slowly") are recorded by the ESP for later use in possible trigger situations.

13. Family members use constructive communication skills when discussing the traumatic event. (19)

19. Meet with family members of ESPs to teach healthy communication skills (e.g., reflective listening, eye contact, respect, etc.) to be used when discussing the stressful work of the ESP family member.

14. Attend the funeral of a coworker who died. (20)

20. Encourage ESP to attend the funeral of his/her coworker to facilitate the grieving process; explore and process his/her reactions afterward.

15. Return to participation in routine daily activities. (21)

16. Monitor own recovery process and seek counseling if maladaptive reactions to the trauma appear. (22, 23, 24)

21. Aid the ESP to identify pleasurable routine daily activities and encourage resuming these; monitor follow-through.

22. Educate the ESP regarding signs of psychological problems associated with poor recovery from the traumatic incident; develop a plan to seek counseling if maladaptive reactions persist (e.g., sleep disturbance, irritability, hyper-vigilance, depression, survivor guilt, etc.).

23. Provide pamphlets and other literature regarding recovery from crises and traumatic events.

24. Provide a list to the ESP of available counseling referral resources.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| V62.2 | Z56.9 | Other Problem Related to Employment |
| V61.10 | Z63.0 | Relationship Distress with Spouse or Intimate Partner |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.21 | F40.00 | Agoraphobia |
| 300.01 | F41.0 | Panic Disorder |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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# DEPRESSION

## BEHAVIORAL DEFINITIONS

1. Depressed mood related to traumatic event consequences.
2. Loss of appetite, weight loss.
3. Diminished interest in or enjoyment of activities.
4. Irritable, short-tempered.
5. Crying spells, tearfulness without provocation.
6. Sleeplessness or hypersomnia.
7. Lack of energy/lethargy.
8. Not bathing, showering, changing clothes, and/or brushing teeth on a regular basis.
9. Poor concentration and indecisiveness.
10. Constricted or flat affect.
11. Social withdrawal.
12. Suicidal thoughts and/or gestures.
13. Feelings of hopelessness, worthlessness, or inappropriate survivor guilt.
14. Low self-esteem.
15. Unresolved grief issues.
16. Mood-related hallucinations or delusions.
17. History of chronic or recurrent depression for which the client has taken antidepressant medication, been hospitalized, or had outpatient treatment.
18. Rumination over past losses (deaths, divorces, separations, etc.) and mistakes.

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## LONG-TERM GOALS

1. Alleviate depressed mood and return to previous level of effective functioning.
2. Develop healthy cognitive patterns and beliefs about self and the world that lead to alleviation and help prevent the relapse of depression symptoms.
3. Develop healthy interpersonal relationships that lead to effective resolution of current conflicts or problems.
4. Appropriately grieve the loss in order to normalize mood and to return to previous adaptive level of functioning.

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## SHORT-TERM OBJECTIVES

1. Describe current and past experiences with depression and its impact on function and attempts to resolve it. (1, 2)

2. Verbally identify, if possible, the source of the depressed mood. (3, 4, 5)

## THERAPEUTIC INTERVENTIONS

1. Assess current and past mood episodes including their features, frequency, intensity, and duration (e.g., Clinical Interview supplemented by Patient Health Questionnaire).
2. Review with the client prior episodes of depression and what coping mechanisms he/she utilized to cope with prior episodes of depression; explore what contributed to this success and encourage the client to repeat it.
3. Ask the client to make a list of what he/she is depressed about; process the list content.
4. Encourage the client to share his/her feelings of depression in order to clarify them and gain insight as to causes.

5. Using a narrative approach, have the client externalize the problem by naming it (see *Narrative Therapy in Practice: The Archaeology of Hope* by Monk, Winslade, Crocket, and Epston).

3. Complete psychological testing to assess the depth of depression. (6)

6. Administer a self-report measure (e.g., Beck Depression Inventory–II or Beck Hopelessness Scale) to assess the depth of depression and suicide risk; evaluate results and give feedback to the client.

4. Verbalize any history of suicide attempts and any current suicidal urges. (7)

7. Explore the client's history and current state of suicidal urges and behavior (see the Suicidal Ideation chapter in *The Complete Adult Psychotherapy Treatment Planner,* 4th ed. by Jongsma, Peterson, and Bruce) if suicide risk is present.

5. State no longer having thoughts of self-harm. (8, 9)

8. Assess and monitor the client's suicide potential.

9. Arrange for psychiatric hospitalization, as necessary, when the client is determined to be harmful to self.

6. Cooperate with an evaluation by a physician or psychiatrist for psychotropic medication. (10, 11)

10. Refer the client to a physician or psychiatrist to rule out organic causes for depression, assess need for a psychotropic medication, and order a prescription, if appropriate.

11. Obtain a release of information to confer regularly with the prescribing physician or psychiatrist; monitor the client's psychotropic medication compliance, side effects, and effectiveness.

7. Identify and replace cognitive self-talk that is engaged in to support depression. (12, 13, 14, 15)

12. Teach the client how to use an automatic thought record to identify and track distorted

cognitions about depression; challenge and replace the cognitive distortions. EBP

13. Assign the client to keep a daily journal of automatic thoughts associated with depressive feelings (e.g., "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma, "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck, Rush, Shaw, and Emery); process the journal material to challenge depressive thinking patterns and replace them with reality-based thoughts. EBP
14. Reinforce the client's positive, reality-based cognitive messages that enhance self-confidence and increase adaptive action (e.g., *Ten Days to Self-Esteem* by Burns or see "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma). EBP
15. Do "behavioral experiments," in which depressive automatic thoughts are treated as hypotheses/predications, reality-based alternative hypotheses/predictions are generated, and both are tested against the client's past, present, and/or future experiences. EBP

EBP 8. Utilize behavioral strategies to overcome depression. (16, 17, 18)

16. Assist the client in developing coping strategies (e.g., more physical exercise, less internal focus, increased social involvement, more assertiveness, greater need for sharing, more anger expression) for reducing feelings of depression; reinforce success in session. EBP

17. Engage the client in "behavioral activation" by scheduling activities that have a high likelihood of pleasure and mastery (see "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); use rehearsal, role-playing, role reversal, as needed, to assist adoption in the client's daily life; reinforce success.

18. Employ self-reliance training in which the client assumes increased responsibility for routine activities (e.g., cleaning, cooking, shopping); reinforce success.

9. Identify individuals who will offer support in times of distress. (19, 20)

19. Engage the client in drawing an eco-map to identify people whom the client can rely upon for support; review the eco-map, encouraging the client to have frequent communication with supportive people.

20. Inquire about the client's religious/ spiritual beliefs, and encourage him/her to use this resource for support; monitor frequency of contact and compliance in contacting.

10. Identify conflicts surrounding relationships, past and present, which could be contributing to depression. (21)

21. Assess the client's *interpersonal inventory* of important past and present relationships and evidence of potentially depressive themes such as grief, interpersonal disputes, role transitions, and interpersonal deficits (see *Comprehensive Guide to Interpersonal Psychotherapy* by Weisman, Markowitz, and Klerman).

11. Verbalize any unresolved grief issues that may be contributing to depression. (22)

22. Explore the role of unresolved grief issues as they contribute to the client's current depression

(see the "Grief/Loss Unresolved" chapter in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

12. Articulate feelings of grief to facilitate the mourning process. (23)

23. Utilizing the Gestalt empty-chair technique, have the client talk to the deceased person, verbalizing his/her feelings associated with the loss (sadness, anger, betrayal, abandonment, relief, etc.). Review with the client how articulating their negative emotions can positively move them through the natural mourning and grief process.

13. Learn and implement problem-solving and/or conflict resolution skills to resolve interpersonal problems. (24, 25, 26)

24. Teach the client conflict-resolution skills (e.g., empathy, active listening, *I messages*, respectful communication, assertiveness without aggression, compromise) to help alleviate depression; use modeling, role-playing, and behavior rehearsal to work through several current conflicts.

25. Help the client resolve depression related to interpersonal problems through the use of reassurance and support, clarification of cognitive and affective triggers that ignite conflicts, and active problem-solving (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

26. In conjoint sessions, help the client resolve interpersonal conflicts.

14. Implement a regular exercise regimen as a depression reduction technique. (27, 28)

27. Develop and reinforce a routine of physical exercise for the client.

28. Recommend the client read and implement exercise programs

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| | (e.g., *Exercising Your Way to Better Mental Health* by Leith); process material read. EBT |
| EBT 15. Learn and implement relapse prevention skills. (29) | 29. Build the client's relapse prevention skills by helping him/her identify early warning signs of relapse, reviewing skills learned during therapy, and developing a plan for managing challenges. EBT |
| 16. Read books on overcoming depression. (30) | 30. Recommend that the client read self-help books on coping with depression (e.g., *Feeling Good: The New Mood Therapy Revised and Updated* by Burns or *The Cognitive Behavioral Workbook for Depression: A Step-by-Step Program* by Knaus); process material read. |
| 17. Show evidence of daily care for personal grooming and hygiene with minimal reminders from others. (31) | 31. Monitor and redirect the client on daily grooming and hygiene. |
| 18. Increasingly verbalize hopeful and positive statements regarding self, others, and the future. (32, 33) | 32. Assign the client to write at least one positive affirmation statement daily regarding himself/herself and the future. |
| | 33. Teach the client more about depression and to accept some sadness as a normal variation in feeling. |
| 19. Develop a plan of action for the resolution of the acute crisis. (34, 35, 36) | 34. Assist the client in developing a plan of action he/she can take to effectively resolve the acute crisis situation; use modeling, role-playing, and behavior rehearsal to work through options. Confront resistance while providing corrective feedback toward improvement. |
| | 35. Teach problem-solving strategies involving specifically defining a problem, generating options for |

addressing it, evaluating options, implementing a plan, and reevaluating and refining the plan.

36. Assign the client a homework exercise in which he/she problem-solves a current problem (see *Mastery of Your Anxiety and Worry: Workbook,* 2nd ed. by Craske and Barlow); review, reinforce success, and provide corrective feedback toward improvement.

20. Verbalize an understanding of the relationship between depressed mood and repression of feeling—that is, anger, helplessness, hurt, and so on. (37)

37. Explain a connection between previously unexpressed (repressed) feelings of anger (and helplessness) or hurt and current state of depression.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| 296.xx | F31.xx | Bipolar I Disorder |
| 296.89 | F31.81 | Bipolar II Disorder |
| 301.13 | F34.0 | Cyclothymic Disorder |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 296.3x | F33.x | Major Depressive Disorder, Recurrent Episode |
| 295.70 | F25.0 | Schizoaffective Disorder, Bipolar Type |
| 295.70 | F25.1 | Schizoaffective Disorder, Depressive Type |
| 301.83 | F60.3 | Borderline Personality Disorder |
| 301.50 | F60.4 | Histrionic Personality Disorder |
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# DISASTER

## BEHAVIORAL DEFINITIONS

1. Involvement in a natural disaster (e.g., tornado, hurricane, flood, blizzard, volcanic eruption, earthquake, wildfire, drought, and so on).
2. Involvement in a man-made or technological disaster (e.g., arson, plane crash, chemical spill, terrorist attack, explosion, and so on).
3. Involvement in a social/health disaster (e.g., war, economic depression, pandemic, and so on).
4. Devastation of, or extreme disruption to home, community, and/or personal belongings, resulting in a severe and/or prolonged disruption of daily routines.
5. Emotional reactions of shock, disbelief, confusion, helplessness, loss of control, and/or guilt causing irritability, anxiety, despair, fear, and/or anger.
6. Inability to regulate emotions that result in impaired daily activities.
7. Disruption to typical sleep patterns, normal appetite, and other daily, routine activities.
8. Increased tension in families causing marital discord, domestic violence, and/or child abuse.
9. Significant increase and prolonged use of alcohol or other mood-altering substances following the disaster.
10. Regressive behaviors, changes in typical family interactions, changes in typical social interaction outside the family, increased aggressive behaviors, risk-taking behaviors in children and adolescents.
11. Re-experience the disaster in thoughts, dreams, flashbacks, or recurrent images.
12. Marked avoidance of stimuli that arouse recollections of the disaster such as thoughts, feelings, conversations, activities, places, or people.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning including resumption of routine daily activities.
2. Demonstrate appropriate levels of emotional, behavioral, and cognitive functioning.
3. Reduce physical complaints.
4. Re-affirm a sense of meaning for the future.
5. Return of a sense of safety to self and family.
6. Experience a sense of community.

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## SHORT-TERM OBJECTIVES

1. Stay in areas that are safe and obtain any necessary medical care. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Cooperate with law enforcement and disaster relief workers to limit the client from entering areas that are unsafe (e.g., damaged buildings, flooded areas, areas with live electrical wires).
2. Refer the client to a first aid station and/or emergency room for medical evaluation and assistance.

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| 2. Volunteer disaster relief workers take direction for greatest effectiveness. (3, 4) | 3. Designate a person(s) to guide volunteers to where they are needed.<br>4. Provide training to volunteers as needed and written guidelines for offering assistance to the client. |
| 3. Locate and utilize shelters for sleeping and to receive basic necessities such as food and clothing. (5, 6) | 5. Provide the client transportation to shelters established by philanthropic organizations (e.g., American Red Cross, faith-based organizations, disaster relief organizations, social service agencies) in order to secure clothing, food, personal hygiene products, and other things needed for daily functioning.<br>6. Make and publish a list of shelters and identify the client using these. |
| 4. Locate and communicate with family, friends, neighbors, and coworkers. (7) | 7. Set up communication boards for the client to leave notes to contact family and friends. |
| 5. Allow client/family to explore their perceptions of the incident. (8, 9) | 8. Use active listening skills to facilitate the controlled expression of the client's affective and cognitive reactions while they recount the trauma in as much detail as they are comfortable with (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).<br>9. Inquire what the client saw, heard, and physically felt when the disaster took place. |
| 6. Contact shelters for animals to locate lost pet. (10) | 10. Assist the client in contacting agencies that shelter pets following a disaster. |
| 7. Decrease reliance on self-medication through the use of alcohol or other mood-altering | 11. Assess the client for increased use of alcohol and other mood-altering substances following the |

substance as a way to cope with the event. (11)

event that are used as a means of coping with the trauma; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary.

8. Implement calming and coping strategies to manage the reactions to the disaster. (12, 13)

12. Train the client to use stress inoculation strategies such as relaxation, breathing control, covert modeling (e.g., imagining the successful use of the strategy), and/or role-playing (e.g., with a therapist or trusted friend) to manage fears.

13. Use systematic desensitization with client about the disaster to describe the experience at an increasing but client-chosen level of detail; repeat until associated anxiety reduces and stabilizes; review and reinforce progress.

9. Identify, challenge, and replace biased, fearful self-talk about the disaster with reality based, positive self-talk. (14, 15)

14. Use homework exercises (e.g., journaling) in which the client identifies fearful self-talk and creates reality-based alternatives; reinforce success, providing corrective feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

15. Challenge negative biases through exploring the client's schema and self-talk that mediates incident-related fears; assist client in generating appraisals that correct for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

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| 10. Family members use healthy communication skills when discussing the disaster. (16, 17) | 16. Teach family members of client constructive communication skills (e.g., reflective listening, eye contact, respect, etc.) to be used when discussing the disaster. |
| | 17. Use modeling, role-playing, corrective feedback, and positive reinforcement to teach caregivers communication skills such as assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner to use with children. |
| 11. Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within the family. (18) | 18. Assign the family a homework exercise to use and record newly learned communication skills; process results in session, providing corrective feedback toward improvement. |
| 12. Learn and implement problem-solving and conflict-resolution skills. (19, 20) | 19. Assist the family in identifying conflicts that can be addressed using communication, conflict resolution, and/or problem-solving skills. |
| | 20. Teach the family problem-solving skills (e.g., pinpoint the problem, brainstorm possible solutions, list the pros and cons of each solution, select and implement a solution, evaluate the outcome, modify the solution if necessary); role-play the application of this process to a family issue of conflict. |
| 13. Attend a support group for client to discuss feelings and perceptions of the event. (21) | 21. Assist in setting up support groups with voluntary attendance to allow survivors to share experiences; encourage the client to consider attending the group. |

14. Identify positive consequences that may have resulted from the disaster. (22)

22. Use reframing with the client/family to explore and identify positive changes (e.g., closer family relationships, increased appreciation of future) associated with positive recovery and resiliency following a disaster.

15. Return to the site of the disaster: home, work, school, and so on. (23)

23. Accompany the client in returning to the home/work/school devastated by the disaster; process the client's reactions to seeing the devastation for the first time.

16. Begin cleaning, sorting through possessions, and rebuilding home, work, school, and community. (24, 25)

24. Encourage the client to seek irreplaceable, valued items in the rubble, assuming it is safe; educate the client on ways to temporarily preserve those items found (e.g., briefly wash off mud/smoke from the item, store it in plastic bag, take the sealed bags to the freezer until time can be taken to restore the item properly).

25. Establish a plan with the client/family for cleaning, repairing, and/or sorting through their belongings at home, work, or school. Advise them not to stop, clean, sort, and reminisce about every item they encounter.

17. Contact private and government agencies that can provide aid to disaster victims. (26, 27)

26. Provide information to assist the client/family in receiving aid and/or compensation from various organizations (e.g., federal and state emergency management agencies [FEMA, SEMA], faith-based organizations, disaster relief agencies, insurance companies).

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| | 27. Refer the client/family to people knowledgeable about completing the forms to receive assistance and/or compensation and provide emotional support in this tedious process. |
| 18. Engage in positive, healthy restoration actions (e.g., helping other clients, cleaning up the community). (28) | 28. Encourage the client/family to assist others as the media and volunteers leave; educate the client that small acts of kindness, both received and given, will maintain morale and build a sense of community during the recovery. |
| 19. Attend and participate in memorial services for the deceased. (29, 30) | 29. Assist in setting up memorial services and sites to honor and remember the deceased. |
| | 30. Assure the client/family that there are no right or wrong feelings and that grief is a normative reaction to loss. |
| 20. Return to typical daily routines in a timely manner. (31, 32) | 31. Educate the client about the importance of maintaining adequate eating and personal hygiene habits such as sleeping patterns; suggest ways to maintain these such as journaling and relaxation techniques. |
| | 32. Assist the client/family in resuming daily activities that were healthy and pleasurable. |
| 21. Maintain focus on present rather than the past or future. (33) | 33. Acknowledge the client's desire for answers, but redirect him/her from focusing on *why* questions to identify the affect behind the questions. |
| 22. Share the financial implications of the disaster and loss of income. (34) | 34. Inquire regarding the economic impact of the disaster on the client's financial situation (e.g., loss of income, paying bills, mortgage, and so on) and identify sources of economic support |

(e.g., life insurance, family and friends, government entitlement programs, and so on).

23. Establish a plan for disaster preparedness in the future. (35)

35. Assist the client in developing a disaster plan to increase a sense of preparedness and safety, thereby decreasing feelings of helplessness; include in the plan: a meeting location, a checklist of appliances and services to be turned off, and two escape routes out of every room in a residence. Encourage them to practice the plan through drills.

24. Report an increased sense of safety in the community. (36)

36. Assist community and social agencies in reviewing the implementation of a crisis plan (e.g., communicating, emergency notification systems, logistics involvement of outside agencies, involvement of emergency responders) in order to revise this. Communicate this to the residents of the community, including the client.

25. Agree to access mental health services if grieving interferes with daily functioning. (37, 38, 39)

37. Educate the client about possible psychological complications (e.g., flashbacks, depression, suicidal ideations) to the traumatic disaster that would require additional intervention.

38. Provide the client with a list of available mental health referral resources.

39. Provide the client with pamphlets and other literature regarding grief and bereavement.

26. Cooperate with an assessment to determine the presence or absence of an ongoing dysfunctional reaction to the trauma. (40, 41)

40. Administer to the client assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Symptom

Checklist–90–Revised, Trauma Symptom Inventory–2, Traumatic Life Events Questionnaire, Family Crisis Oriented Personal Evaluation Scales [F-COPE], Beck Depression Inventory–II) to identify an at-risk client, monitor the recovery process, and guide treatment.

41. Conduct suicide and homicide assessments with the client as needed. 

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| V62.2 | Z56.9 | Other Problem Related to Employment |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.21 | F40.00 | Agoraphobia |
| 300.01 | F41.0 | Panic Disorder |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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# DOMESTIC VIOLENCE

## BEHAVIORAL DEFINITIONS

1. Self-report of being injured, threatened, or verbally abused by a spouse or domestic partner coupled with feelings of fear, insecurity, and/or social withdrawal/avoidance.
2. Bruises, injuries, and/or physical complaints that give evidence of physical assault (e.g., hitting, slapping, shoving, choking, restraining, etc.) by spouse/partner.
3. Verbal abuse (e.g., threatened, intimidated, derogatory comments, extensive use of profanity, being blamed for anything that goes wrong in the relation-ship, etc.) by spouse/partner.
4. Emotional or psychological abuse (e.g., being stalked, controlled, prohibited contact with family/support systems, deny access to money/resources, etc.) by the spouse/partner.
5. Sexual assault (e.g., nonconsensual sexual intercourse, sodomy, harming if intercourse is refused, etc.) by spouse/partner.
6. Depressed mood, irritability, anxiety, difficulty sleeping, poor concentration, motor restlessness.
7. Low self-esteem as evidenced by minimal or no eye contact, self-disparaging/blaming statements, helplessness, hopeless, and social withdrawal.
8. Subjective sense of numbing, detaching, or absence of emotional responsiveness.
9. Avoidance of people and activities that remind self of the abusive relationship.

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## LONG-TERM GOALS

1. Eliminate all physical, emotional, sexual, or verbal abuse in the relationship.
2. Take legal steps necessary to guarantee safety and follow through with legal action against the abusive spouse/partner.
3. Develop the skills necessary to maintain physical and emotional safety in current and future relationships.
4. Return to the level of psychological, emotional, social, and occupational functioning present before the abuse began.
5. Assimilate the assault event into daily life experiences as a resilient survivor rather than a hopeless victim.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Describe the history, nature, frequency, and duration of domestic abuse. (1, 2) | 1. Speaking with the client alone, establish rapport by providing unconditional positive regard, asking open-ended questions, and maintaining a supportive, nonjudgmental attitude.<br>2. Gather from the client a history of the physical, emotional, verbal, or sexual abuse that has been endured, determining when the abuse began, situations that occurred prior to the start of the current abuse, as well as past abusive events. |
| 2. Cooperate with a medical assessment and evidence collection related to the assault. (3, 4) | 3. Refer the client to a physician trained in domestic abuse examinations for evidence collection and evaluation of any |

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| | injuries; monitor the client's compliance with the assessment and treatment recommendations. |
| | 4. Assist in getting the client to her/his physician, urgent care, or emergency department for a medical evaluation. |
| 3. Describe emotional reactions experienced since the abuse and how daily functioning has been impacted. (5, 6) | 5. Explore the client's feelings associated with the abuse, including those of guilt, shame, helplessness, fear, anger, and/or self-blame. |
| | 6. Create with the client a symptom time line to identify how the abuse has negatively impacted her/his life, including how activities of daily living have changed to avoid confrontation, vulnerability, or shame. |
| 4. Verbalize symptoms of anxiety or depression, including any homicidal thoughts. (7, 8) | 7. Administer to the client a self-report measure (e.g., Beck Depression Inventory–II; General Anxiety Disorder–7 [GAD-7]; Beck Hopelessness Scale by Beck; Conflict Tactics Scales, Revised [CTS2]) to assess the depth of depression and/or anxiety symptoms and homicide risk; evaluate the results and give feedback to the client. |
| | 8. Assess and monitor the client's suicide or homicide potential; arrange for psychiatric hospitalization, as necessary. |
| 5. Identify and replace cognitive messages that promote fear, worry, or anxiety. (9, 10, 11) | 9. Discuss facts of the abuse (review photographs of the assault, medical/police documents, previous history of violence) to explore the client's possible distorted cognitive messages that intensify the negative emotional reactions to the abuse. |

10. Help the client develop reality-based cognitive messages that will enhance self-confidence, increase adaptive actions, and facilitate a reduction in fear, worrying, or anxiety responses (see "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).
11. Teach the client how to use an automatic thought record to identify and track distorted cognitions about the abuse; challenge the thoughts and assist him/her in replacing the cognitive distortions related to the abuse with more realistic messages.

6. Verbalize an understanding of the cycle of domestic violence. (12, 13, 14, 15)

12. Educate the client about the cycle of domestic violence (e.g., tension-building, acute battering, followed by the calm, loving phase/the honeymoon phase); challenge hopeless thinking patterns and replace them with reality-based thoughts.
13. Teach the client to journal how the abuser manipulates the client's hope by expressing remorse, displaying emotional distress, or pleading for forgiveness after the assault; review and reinforce success in sessions, providing corrective feedback for failure.
14. Do behavioral experiments in which defeatist automatic thoughts are treated as hypotheses/predications, reality-based alternative hypotheses/predictions are generated, and both are tested against the client's past, present, and/or future experiences.

15. Recommend that the client read self-help books on the cycle of domestic violence (e.g., *The Battered Woman Syndrome,* 3rd ed. by Walker; *Getting Free: You Can End Abuse and Take Back Your Life* by NiCarthy; or *Anger Busting 101: The New ABCs for Angry Men & the Women Who Love Them* by Hightower); process material read.

7. Identify, challenge, and replace self-blame with an understanding that the perpetrator is responsible for the assault. (16, 17, 18)

16. When the client expresses guilt, shame, helplessness, fear, anger, and/or self-blame; redirect the client to view the assault as a crime committed against her/him for which the perpetrator is to blame.

17. Confront and challenge any of the client's minimizing or making excuses regarding the seriousness of the assault; assess if the client believes the perpetrator's remorse means the abuse will never happen again and she/he is to blame for the assault.

18. Assign the client a journaling homework exercise in which he/she identifies self-talk and takes the blame for the assault and then creates alternative reality-based thoughts (the abuse as a violation committed against him/her that happened beyond his/her control, placing the blame on the perpetrator); review and reinforce success in sessions, providing corrective feedback for failure.

8. Learn and implement problem-solving strategies to reduce the negative impact the assault has

19. Assist the client in generating a list of all abusive behaviors (e.g., jealousy, controlling, quick

had on intimacy or sexual relations. (19, 20, 21, 22)

commitment, unrealistic expectations, isolation, blames others, hypersensitivity, animal cruelty, rigid gender roles, property destruction, etc.); review list, reinforcing avoidance of another abusive relationship in the future.

20. Teach problem-solving strategies when indicators of impending domestic violence occur, generating options for addressing it, evaluating the pros and cons of the options, selecting and implementing an option, and reevaluating and refining the action taken.

21. Encourage the client to openly communicate with her/his sex partner her/his difficulties with intimacy/sexual relations; use modeling, role-playing, and behavior rehearsal to work through conflicts.

22. Explore with the client what life would look like if the abuse had never happened; review response and encourage steps to begin living that life.

9. Learn and implement assertiveness techniques to increase self-confidence. (23, 24, 25)

23. Teach the client assertiveness techniques emphasizing the maintenance of physical safety boundaries (eye contact, posture, personal space, active listening, broken record, etc.) to be used with confidence when feeling threatened; use rehearsal, role-playing, and role reversal for success.

24. Encourage the client to talk about ambivalence toward the abuser and toward terminating the relationship; confront

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| | unrealistic expectations for change, emphasize the need to take responsibility for protecting self from future abuse. |
| | 25. Verbally reinforce the client's use of positive statements regarding confidence and accomplishments. |
| 10. Verbalize an understanding of the relationship between past abusive experiences and tolerance for the current abusive actions. (26, 27) | 26. Explore experiences from the client's childhood that taught her/him to excuse abusive behavior; teach appropriate limits and boundaries for behavior. |
| | 27. Engage the client in drawing a genogram to identify relationships in his/her past that contained emotional, verbal, physical, sexual abuse, and/or incest (including witnessing abuse between parents or other adults in their childhood); discuss how this has contributed to her/his tolerance for the abuse occurring currently. |
| 11. Provide honest and complete information for a chemical dependence biopsychosocial history, identifying how substance use contributed to the violence. (28, 29, 30) | 28. Assess the client for the presence of chemical dependence; educate her/him on the influence of chemical use before, during, or after violent episodes; monitor compliance. |
| | 29. Use a biopsychosocial history to help the client understand the familial, emotional, and social factors that contributed to the development of chemical dependence. |
| | 30. Refer the client for treatment for chemical dependence and/or 12-step group to establish and maintain sobriety. |

12. Develop a safety plan for protection from ongoing abuse. (31, 32)

31. Develop a written safety plan that details what actions will be taken to establish and maintain physical and emotional safety (e.g., filing a police report, obtaining an order of protection or personal restraining order, utilizing a battered women's shelter, leaving the residence, contacting support persons, purchasing a cordless/wireless phone, identifying an escape route, etc.).

32. Discuss with the client what family members/support systems would be willing and able to provide a safe, protected living situation; encourage the client to move in with those individuals until safety is established; monitor compliance and progress.

13. Cooperate with authorities in their investigation. (33, 34)

33. Encourage the client to work collaboratively with law enforcement in their investigation; utilizing legal resources available for victims of abuse (e.g., attorneys, legal aid, victim advocacy programs); confront any resistance such as fear of retaliation, feelings of hopelessness or helplessness, etc., by reminding the client of the need to establish and maintain her/his safety.

34. Assess for implied or stated harm to the client's family members/children, friends, or support systems by the abuser; assess realistic level of harm to others, taking the necessary advisory precautions and identifying ways safety for all those concerned can be

addressed, including the need to report any suspected child abuse to Children's Protective Services.

14. Identify individuals that will offer physical and emotional support in times of distress. (35)

35. Engage the client in drawing an eco-map to identify people whom the client can rely upon for support; review eco-map, encouraging the client to have frequent communication with supportive people to reduce feelings of insecurity, powerlessness, or anxiety.

15. Participate in a victim of sexual assault support group. (36)

36. Refer the client to a support group that is focused on victims of domestic violence; encourage the client to share her/his abuse experience and its effects with other survivors in the group.

16. Maintain involvement in social and vocational activities, assimilating the traumatic event into daily living. (37, 38, 39)

37. Assist the client in identifying how he/she is going to overcome the negative impact that the domestic abuse has had on his/her functioning at work and in social or family interactions (e.g., prohibiting use of the phone, humiliation of the client in social/family functions, being less productive, isolating self, etc.).

38. Encourage the client to return to work, social engagements, and/or daily routines that occurred prior to the assault; phase these activities into daily living gradually but steadily if necessary.

39. Refer the client to work training programs or employment opportunities/agencies in order to promote economic independence from perpetrator.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.24 | F43.22 | Adjustment Disorder, With Anxiety |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.28 | F43.23 | Adjustment Disorder, With Mixed Anxiety and Depressed Mood |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 303.90 | F10.20 | Alcohol Use Disorder, Moderate or Severe |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 296.2x | F32.x | Major Depressive Disorder, Single Episode |
| 296.3x | F33.x | Major Depressive Disorder, Recurrent Episode |
| V61.11 | Z69.11 | Encounter for Mental Health Services for Victim of Spouse or Partner Violence, Physical |
| 995.81 | T74.11XA | Spouse or Partner Violence, Physical, Confirmed, Initial Encounter |
| 995.81 | T74.11XD | Spouse or Partner Violence, Physical, Confirmed, Subsequent Encounter |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 301.82 | F60.6 | Avoidant Personality Disorder |
| 301.83 | F60.3 | Borderline Personality Disorder |
| 301.6 | F60.7 | Dependent Personality Disorder |
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# JOB LOSS

## BEHAVIORAL DEFINITIONS

1. Elimination of job because of organizational restructuring by the employer (downsizing).
2. Sudden, unexpected termination of employment.
3. Change in physical health (e.g., injury, illness, dismemberment) that prevents continuing current work duties.
4. Wrongful termination due to discrimination (e.g., gender, age, race, disability, appearance) or personal conflict with supervisor.
5. Loss of role identity.
6. Difficulty in concentrating and following directions after the termination.
7. Increased use of alcohol or other mood-altering substances following the loss of employment.
8. Experiencing suspiciousness and mistrust of others following the termination to the point that it interferes with daily functioning.
9. Withdrawal and isolation from social, recreational, and/or occupational activities.
10. Inability to regulate emotions following the loss of employment.
11. Disruption of typical eating habits, sleep patterns, and lack of personal hygiene following the loss of employment.
12. Physical symptoms such as chest pain, chest pressure, shortness of breath, muscle tension, headaches, intestinal upset, heart palpitations, and dry mouth.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning.
2. Restore appropriate levels of affective, cognitive, and behavioral functioning.
3. Reduce physical complaints.
4. Re-establish a sense of meaning for the future.
5. Develop a plan to meet financial needs.
6. Re-establish healthy and appropriate family relationships

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Cooperate with an assessment of affective, behavioral, and cognitive reactions to the loss of employment. (1) | 1. Administer to the client assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Symptom Checklist–90–Revised, Trauma Symptom Checklist, Traumatic Life Events Questionnaire, Family Crisis Oriented Personal Evaluation Scales [F-COPE]) to guide intervention that is needed. |
| 2. Verbalize feelings of anger related to the loss of employment. (2, 3, 4) | 2. Explore the client's feelings about the loss of employment while implementing de-escalation skills (e.g., give undivided attention, empathic listening, reflection of feelings, agree with unjust aspects, avoid arguing, stay calm, give reassurance, etc.) to prevent aggressive or violent actions toward those associated with the loss of employment. |

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| | 3. Assess whether the client's anger is approaching uncontrolled rage leading to aggression; as appropriate, contact law enforcement or other trained individuals who can help behaviorally manage the client. |
| | 4. Notify any intended victims of the client as to the threat of violence as mandated by the legal system. |
| 3. Describe openly and honestly the situation regarding the loss of employment and the feelings associated with it. (5, 6, 7, 8) | 5. Establish rapport by appropriately maintaining eye contact with the client, speaking clearly and slowly, and at the same level (i.e., sitting or standing) as the client. |
| | 6. Ask the client to describe the circumstances surrounding the job loss and explore the client's wide-ranging emotions connected to this loss of employment; reassure the client that emotional reactions are expected in the wake of this incident and assure him/her that there are no right or wrong feelings. |
| | 7. Educate the client that keeping feelings pent up has the potential to increase their strength and allow them to become destructive; facilitate expression of feelings associated with the job loss. |
| | 8. Assess whether the client is overwhelmed with affect or cognitive reactions to the incident; if so, refer for ongoing counseling. |
| 4. Identify trusted family members and friends with whom to share the job loss experience. (9, 10) | 9. Assist the client in listing those people in his/her social network who can be trusted; encourage and facilitate the client sharing his/her affective and cognitive |

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| | reaction with a professional, family member, and/or trusted friend.<br>10. Role-play the client disclosing information about the loss of employment to different people in the community; process the reactions to the exercise. |
| 5. Decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the loss of employment. (11) | 11. Assess the client for increased use of alcohol and other mood-altering substances following the job loss that are used as a means of coping with the loss of employment; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary. |
| 6. Share the financial implications of the job loss and loss of income. (12, 13) | 12. Inquire regarding the economic impact of the client's loss of employment (e.g., loss of income, paying bills, mortgage obligation).<br>13. Facilitate client in making decisions and arrangements related to the loss of employment (e.g., contacting credit card companies, mortgage companies, utility companies, unemployment office). |
| 7. Verbalize an understanding of community and government resources available to the unemployed. (14, 15, 16) | 14. Direct the client to community-based services (e.g., faith-based organizations such as Catholic Charities and the Salvation Army, Unemployment Office, Vocational Rehabilitation Services, food pantries).<br>15. Inform the client about various state and federal programs (e.g., Social Security disability, worker's compensation, unemployment insurance) that may provide assistance; inform him/her about the qualifying criteria for each program. |

16. Assist the client in locating online support for job loss and seeking employment.

8. File for unemployment insurance benefits. (17)

17. Assist the client in completing unemployment insurance application.

9. Submit an application for Social Security disability. (18)

18. Assist the client in completing Social Security disability applications, and advocate for the client during the qualification process.

10. Learn and implement calming and coping strategies to manage the reactions to the job loss. (19)

19. Teach stress management strategies such as relaxation, breathing control, covert modeling (e.g., imagining the successful use of the strategy), and/or role-playing (e.g., with a therapist or trusted friend) until a sense of mastery is evident.

11. Identify, challenge, and replace biased, fearful self-talk about the job loss with reality-based, positive self-talk. (20, 21, 22)

20. Explore the client's schema and self-talk that mediates incident-related fears, challenge negative biases, and assist client in generating appraisals that correct for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

21. Using cognitive behavioral techniques such as positive self-talk, help the client organize his/her thoughts about the loss of employment.

22. Assign the client a homework exercise (e.g., journaling) in which he/she identifies negative self-talk and creates positive, reality-based alternatives (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); review

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| | and reinforce success, providing corrective feedback for failure. |
| 12. Report a reduced level of anxiety related to events surrounding the job loss. (23) | 23. Have the client undergo imaginal exposure to events about the job loss by having him/her describe the experience at an increasing but client-chosen level of detail; repeat until associated anxiety reduces and stabilizes; review and reinforce progress. |
| 13. Consult with an attorney regarding legal rights related to employment and termination. (24) | 24. Refer the client to an attorney who specializes in employment law to review reasons for the loss of job and legal options available. |
| 14. List the pros and cons of staying in current occupation or field of employment. (25) | 25. Guide the client in listing and considering the pro and cons of staying in the current occupation or field of employment. |
| 15. Read books on the employment search process. (26) | 26. Suggest the client read books on job search skills, strategies, and processes (e.g., *What Color Is Your Parachute?* by Bolles). |
| 16. Develop a plan to search for employment. (27, 28) | 27. Educate the client on strategies to locate available jobs (newspaper, job boards, online services, visiting human resource department of potential employers); develop an action plan (or assign "A Vocational Action Plan" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| | 28. Assign the client homework to determine 10 available jobs for which he/she is qualified. |
| 17. Practice job interview skills. (29, 30) | 29. Role-play interviews with the client; provide feedback regarding his/her attire, appearance, speech patterns, and responses to interview questions. |
| | 30. Refer the client to a job coach who can provide assistance with |

resume preparation, job search, and interview skills.

18. Engage in positive, healthy, and constructive social interaction to prevent isolation and withdrawal and build self-esteem. (31)

31. Direct the client to community-based and online self-help groups as well as volunteer opportunities (e.g., faith-based institutions, local hospitals, shelters).

19. Report the ability to obtain a healthy amount of sleep, maintain adequate eating habits, and keep up with personal hygiene. (32)

32. Educate the client about the importance of maintaining adequate sleeping, eating, and personal hygiene habits and help him/her plan ways to accomplish this (e.g., implementing sleep hygiene procedures, eating on a regular schedule, establishing a routine for personal hygiene).

20. Identify positive changes that may have resulted from the loss of employment. (33)

33. Use reframing to help the client explore and identify positive consequences (e.g., closer family relationships, increased appreciation of future, support of family and friends, obtaining a more satisfying job, etc.) associated with the job loss.

21. Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts regarding the loss of employment within the family. (34, 35, 36)

34. Meet with family members of the client to teach them healthy communication skills (e.g., reflective listening, eye contact, respect, etc.) to be used when discussing the loss of employment.

35. Teach the client and family members communication skills including assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner using modeling, role-playing, corrective feedback, and positive reinforcement.

22. Learn and implement problem-solving and conflict-resolution skills to facilitate the recovery process from the loss of employment. (37, 38)

36. Assign the family a homework exercise to use, monitor, and record newly learned communication skills; process results in session, providing corrective feedback toward improvement.

37. Assist the family in identifying conflicts that can be addressed using communication, conflict-resolution, and/or problem-solving skills.

38. Teach the family to pinpoint the problem, brainstorm possible solutions, list the pros and cons of each solution, select and implement a solution, evaluate the outcome, modify the solution if necessary; role-play the application of this process to a family issue of conflict.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| V62.2 | Z56.9 | Other Problem Related to Employment |
| V61.10 | Z63.0 | Relationship Distress with Spouse or Intimate Partner |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
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# MEDICALLY CAUSED DEATH (ADULT)

## BEHAVIORAL DEFINITIONS

1. Sudden death of a person (e.g., death from cardiac arrest, respiratory arrest, aneurysm).
2. Death of a loved one following a prolonged illness (e.g., AIDS, cancer, congestive heart failure).
3. Recurrent, intrusive, traumatic memories, flashbacks, and nightmares (e.g., witnessing the death, receiving death notification) related to the death.
4. Difficulty in concentrating and following directions after the death.
5. Increased use of alcohol or other mood-altering substances following the death.
6. Experiencing shaking, fainting, dry mouth, and/or diaphoresis.
7. Social withdrawal and isolation, avoidance of certain locations and social situations.
8. Inability to regulate emotions following the death.
9. Feelings of guilt regarding the death.
10. Disruption of typical eating habits, sleep patterns, and lack of personal hygiene following the death.
11. Physical symptoms such as chest pain, chest pressure, shortness of breath, muscle tension, headaches, intestinal upset, and heart palpitations.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore appropriate levels of affective, cognitive, and behavioral functioning.
3. Reduce physical complaints.
4. Develop a healthy grieving process.
5. Re-establish a sense of meaning for the future.
6. Re-establish healthy family and other social relationships

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Verbalize an understanding of the cause(s) of death and the lifesaving attempts that took place. (1) | 1. Explore with the client what he/she knows of the loved one's condition or events that have taken place; provide medical facts surrounding the death and inform the client that the love one is dead (using the word *dead* or *died*) and allow for silence following the death notification. |
| 2. Secure medical treatment for injuries and/or complications in reaction to the news that the loved one has died. (2) | 2. Facilitate the client's access to emergency medical services or medical personnel as needed for complaints of chest pain or other medical conditions. |
| 3. List questions to ask medical personnel regarding the deceased including treatment and final moments prior to death. (3) | 3. Provide paper and pen for the client to write questions he/she would like to ask medical personnel. Suggest taking notes when meeting with medical personnel and possibly having a |

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| | friend or other person to help take notes also attend the meeting. |
| 4. Say good-bye to and view the deceased's body. (4) | 4. Prepare the client regarding the appearance of the body (e.g., missing limbs, blood, contusions); support the client physically and emotionally in viewing the deceased's body. |
| 5. Make decisions regarding funeral/ memorial service arrangements. (5) | 5. Facilitate the client making decisions and arrangements related to the funeral (e.g., burial, cremation, memorial service, memorial donations). |
| 6. Control urges for aggressive or violent behaviors toward anyone associated with the death. (6,7, 8,) | 6. Use de-escalation skills to prevent aggressive or violent actions by the client toward medical staff or others associated with the death. |
| | 7. As appropriate, contact law enforcement or other trained individuals who can help behaviorally manage the client. |
| | 8. Inform the client that ignored and unexpressed feelings may intensify those emotions long term or allow such to become destructive. |
| 7. Verbalize an understanding of emotional reactions that are typical responses to the incident. (9) | 9. Assure the client that there are no right or wrong feelings and that grief, anger, and fear are normal reactions to a death. |
| 8. Share the grief experience with children as culturally appropriate. (10) | 10. Encourage the client to openly express his/her grief with his/her children to assist in the grieving process for that culture. |
| 9. Talk with family, friends, and the community about the death. (11, 12) | 11. Role-play with the client disclosing information about the person's death to different people in the community as well as family members and friends. Process the reactions to the exercise. |

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| | 12. Offer to contact family, friends, or others (e.g., minister, pastor, priest, rabbi) to ask them to come and provide support for client. |
| 10. Verbalize a reduced level of anxiety associated with talking about events surrounding the death. (13) | 13. Have the client undergo imaginal exposure to events about the death by having him/her describe the experience at an increasing but client-chosen level of detail; repeat until associated anxiety reduces and stabilizes; review and reinforce progress, assess for a reduction of problem-solving obstacles. |
| 11. Family members use healthy communication skills when discussing the person's death. (14, 15) | 14. Teach family members healthy communication skills (e.g., reflective listening, eye contact, respect, etc.) to be used when discussing the person's death. |
| | 15. Use modeling, role-playing, corrective feedback, and positive reinforcement to teach the family assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner. |
| 12. Explore perceptions of the death. (16, 17) | 16. Use active listening skills to explore the client's affective, behavioral, and cognitive reactions while he/she recounts the incident in as much detail as he/she is comfortable with (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| | 17. Facilitate the client's controlled expression of feelings by placing limits, allowing them to be |

articulated in a safe, non-threatening manner.

13. Identify, challenge, and replace biased, fearful self-talk regarding the death with reality-based, positive self-talk. (18, 19)

18. Identify fearful self-talk and develop reality-based alternatives using homework assignments such as journaling; review and reinforce success, providing corrective feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

19. Explore the client's thought processes and self-talk that mediate incident-related fears; challenge negative biases and assist him/her in generating appraisals that correct for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

14. Learn and implement calming and coping strategies to manage the anxious reactions to the death. (20)

20. Teach the client strategies from stress inoculation training such as relaxation, breathing control, covert modeling (e.g., imagining the successful use of the strategy), and/or role-playing (e.g., with a therapist or trusted friend) for managing reactions until a sense of mastery is evident.

15. Verbalize a resolution of irrational guilt feelings related to the death. (21, 22)

21. Dispute the client's unreasonable sense of guilt over the death, exploring and replacing irrational thoughts with realistic thoughts.

22. Explore with client(s) regrets by asking about what he/she believes could have, should have, or would have been done.

16. Express thoughts and feelings that were disappointedly left unexpressed to the deceased. (23)

17. Learn and implement problem solving and conflict-resolution skills for issues related to the death. (24, 25)

18. Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within the family to be used in the grief process. (26)

19. Limit the time to focus on grieving the loss. (27)

20. Identify positive consequences that may have resulted from the death. (28)

23. Explore with client what he/she wished had been said to the deceased before the death; utilize the empty chair technique to facilitate this discussion.

24. Assist the family in identifying conflicts associated with the death that can be addressed using communication, conflict-resolution, and/or problem-solving skills.

25. Teach the family problem-solving skills (i.e., pinpoint the problem, brainstorm possible solutions, list the pros and cons of each solution, select and implement a solution, evaluate the outcome, modify the solution if necessary); role-play the application of this process to a family issue of conflict.

26. Assign the family a homework exercise to use, monitor, and record newly learned communication skills; process results in session, providing corrective feedback toward improvement.

27. Suggest a time-limited period and place be set aside each day for the client to focus on the loss (e.g., 20 minutes in the morning and a specific location); after the time is completed, the client will engage in typical daily activities.

28. Use reframing to explore and identify positive changes (e.g., closer family relationships, increased appreciation of future) associated with positive recovery and resiliency following a death.

21. Decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the death. (29)

29. Assess the client for increased use of alcohol and other mood-altering substances following the event that are used as a means of coping with the death; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary.

22. Maintain focus on present rather than the past or future. (30)

30. Acknowledge the desire for answers but redirect client(s) from focusing on *why* questions to identify the affect behind the questions.

23. Restore routine daily functions in a timely manner. (31)

31. Inform the client about the importance of maintaining adequate eating, personal hygiene habits, and healthy sleeping patterns; suggest ways to maintain these through journaling and relaxation techniques.

24. Read popular media such as books and DVDs to better understand the grief experience and increase a sense of hope. (32)

32. Assign the client to read books on grief (e.g., *Good Grief* by Westberg, *How to Go on Living When Someone You Love Dies* by Rando) or watch DVDs (e.g., *Terms of Endearment, On Golden Pond, Ordinary People*) that focus on grieving. Discuss with the client(s) how those characters coped with loss and expressed their grief.

25. Connect with community-based resources that can provide support. (33)

33. Direct the client to community-based services (e.g., faith-based organizations, Parents Without Partners, Widowed Person Services, online groups such as GriefNet.org and groww.org) for emotional support.

26. Implement a plan of constructively reacting to the economic consequences of the death of a partner. (34)

34. Inquire of the client regarding the economic impact of the death (e.g., loss of income, paying bills, mortgage, and so on) and

identify source for support (e.g., life insurance, family and friends, government entitlement programs), exploring plans for ways to meet economic needs.

27. Begin the process of disposing of the deceased's belongings. (35)

35. Explore the client's need to clean the deceased's room, take care of belongings, distribute clothes, and so on. Recommend this process to be gradual to avoid feeling overwhelmed or regretting decisions that cannot be reversed.

28. Cooperate with completing objective assessment instruments to determine the presence or absence of ongoing dysfunctional reactions to the trauma. (36, 37)

36. Administer to the client assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Symptom Checklist–90–Revised, Trauma Symptom Checklist, Traumatic Life Events Questionnaire, Family Crisis Oriented Personal Evaluation Scales [F-COPE], Beck Depression Inventory–II) to monitor the recovery process for guide treatment.

37. Conduct suicide and homicide assessments with the client as needed.

29. Agree to access mental health services if grieving interferes with daily functioning. (38, 39, 40)

38. Educate the client about possible psychological complications (e.g., flashbacks, depression, suicidal ideations) to the traumatic death that would require additional mental health services.

39. Provide the client with lists of available mental health referral resources.

40. Provide the client with pamphlets and other literature regarding grief and bereavement.

30. Design and implement a memorial activity for the anniversary day of the loved one's death or around life events (e.g., birthday, holidays). (41)

41. Identify and explore with the client rituals or family traditions, and create plans to remember the loved one on an anniversary of importance (e.g., going to the grave, having a special family meal).

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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# MEDICALLY CAUSED DEATH (CHILD)

## BEHAVIORAL DEFINITIONS

1. Sudden death of a child (e.g., death from cardiac arrest, respiratory arrest, aneurysm).
2. Death of a child following a prolonged illness (e.g., cancer)
3. Recurrent, intrusive, traumatic memories, flashbacks, and nightmares (e.g., witnessing the death, receiving death notification) related to the death.
4. Difficulty in concentrating and following directions after the death.
5. Increased use of alcohol or other mood-altering substances following the death.
6. Experiencing shaking, fainting, dry mouth, and/or diaphoresis.
7. Social withdrawal and isolation, avoidance of certain locations and social situations.
8. Inability to regulate emotions following the death.
9. Feelings of guilt regarding the death.
10. Disruption of typical eating habits, sleep patterns, and lack of personal hygiene following the death.
11. Physical symptoms such as chest pain, chest pressure, shortness of breath, muscle tension, headaches, intestinal upset, and heart palpitations.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore appropriate levels of affective, cognitive, and behavioral functioning.
3. Reduce physical complaints.
4. Develop a healthy grieving process.
5. Re-establish a sense of meaning for the future.
6. Re-establish healthy family and other social relationships

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## SHORT-TERM OBJECTIVES

1. Verbalize an understanding that the child has died. (1, 2)

2. Secure medical treatment for complications in reaction to the news that the child has died. (3)

## THERAPEUTIC INTERVENTIONS

1. Establish rapport by appropriately maintaining eye contact with the caregivers and siblings, speaking clearly and slowly, and at the same level (i.e., sitting or standing) as the caregivers and siblings.

2. Identify the caregivers and siblings and gather them in a secure, private room/area to communicate the death notice; inform the client(s) that the loved one is dead (using the word *dead* or *died*) and allow for silence following the death notification.

3. Facilitate the caregiver's and sibling's access to emergency medical services or medical personnel as needed for

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| | complaints of chest pain or other medical conditions. |
| 3. Control urges for aggressive or violent behaviors toward anyone associated with the child's death. (4, 5) | 4. Use de-escalation skills to prevent aggressive or violent actions by the caregivers and siblings toward medical staff or others associated with the death. |
| | 5. As appropriate, contact law enforcement or other trained individuals who can help behaviorally manage the caregivers and siblings. |
| 4. List questions to ask medical personnel regarding the deceased including treatment and final moments prior to death. (6) | 6. Provide paper and pen for the caregivers and siblings to write questions they would like to ask medical personnel; suggest taking notes when meeting with medical personnel and possibly having a friend or other person to help take notes also attend the meeting. |
| 5. Say good-bye to, view, and hold the child's body. (7, 8) | 7. Prepare the caregivers and siblings to view the child and provide physical and emotional support during their viewing of the child's body. |
| | 8. Educate the caregivers and siblings that viewing the child in the environment of his/her death prevents distorted images that may develop in the future about how the child died. |
| 6. Make a decision about participation in the organ donation program. (9) | 9. Inform the caregivers about organ donations, including that the child's body will not be disfigured and that there is no cost to the family; refer them to medical staff for additional information. |
| 7. Make decisions regarding funeral/ memorial service arrangements. (10) | 10. Facilitate the caregivers and siblings in making decisions and arrangements related to the |

funeral (e.g., burial, cremation, memorial service).

8. Learn and implement calming and coping strategies to manage the reactions to the child's death. (11, 12)

11. Teach the caregivers and siblings strategies such as relaxation techniques, breathing control, covert modeling (e.g., imagining the successful use of the strategy), and/or role-playing (e.g., with a therapist or trusted friend) for managing fears associated with the death until a these no longer cause undue concern.

12. Assign the caregivers and siblings a homework exercise to identify fearful self-talk and construct reality-based alternatives; review and reinforce success, providing corrective feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

9. Use cognitive behavioral strategies to manage feelings of anxiety and panic related to the child's death. (13)

13. Teach the caregivers and siblings strategies from stress inoculation training such as relaxation, breathing control, covert modeling (e.g., imagining the successful use of the strategy), and/or role-playing (e.g., with a therapist or trusted friend) for managing reactions until a sense of mastery is evident.

10. Communicate with the deceased's school regarding arrangements for the child's service and memorial. (14)

14. Liaison with the deceased's school to communicate the caregiver's wishes regarding issues related to the child's funeral and memorial service.

11. Verbalize any feelings of blame associated with the death. (15)

15. Educate the caregivers and siblings that keeping feelings pent up has the potential to increase their strength and allow them to become destructive.

12. Allow caregivers and siblings to explore their perceptions of the death. (16)

13. Caregivers and siblings verbalize what they will say when talking with family, friends, and the community about the death. (17, 18)

14. Adult survivors/caregivers provide emotional support to surviving sibling(s) of deceased. (19, 20)

15. Verbalize an understanding that feelings of grief are natural. (21)

EBT 16. Identify, challenge, and replace biased, fearful self-talk associated with the child's death with reality based, constructive self-talk. (22, 23)

16. Use active listening skills to support the controlled expressions of the caregivers' and siblings' affective and cognitive reactions while they recount the event in as much detail as they are comfortable with (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

17. Practice disclosing information about the child's death to different people in the community as well as other family members and friends. Process the reactions to the exercise.

18. Offer to contact family, friends, or others (e.g., minister, pastor, priest, rabbi) to ask them to come and provide support for the caregivers and siblings.

19. Encourage the caregivers to share their emotional reactions with the surviving sibling(s).

20. Alert caregivers about the ways children grieve at different ages and the ways caregiver(s) can be supportive; ask the caregivers to identify the grief reactions seen in the children.

21. Assure the caregivers and siblings that there are no right or wrong feelings and that grief is a culturally learned experience that needs healthy expression.

22. Explore the caregiver's and sibling's schema and self-talk that causes fears related to the death; challenge negative biases and assist him/her in generating realistic appraisals that correct

for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

23. Have the caregivers and siblings use images associated with the death to reduce anxiety; repeat until associated anxiety stabilizes; review and reinforce progress, while problem solving for obstacles.

17. Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within the family related to the child's death. (24, 25, 26)

24. Inform the families of the benefit of using healthy communication skills to discuss the death.

25. Use behavioral techniques such as modeling, role-playing, corrective feedback, and positive reinforcement to teach the family communication skills including assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner.

26. Assign the family a homework exercise to use, monitor, and record newly learned communication skills; process results in session, providing corrective feedback toward improvement.

18. Learn and implement problem-solving and conflict-resolution skills for issues associated with the child's death. (27, 28)

27. Assist the family to identify issues and conflicts related to the grieving process that can be addressed using communication, conflict-resolution, and/or problem-solving skills.

28. Teach the family problem-solving skills (e.g., pinpoint the

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| | problem, brainstorm possible solutions, list the pros and cons of each solution, select and implement a solution, evaluate the outcome, modify the solution if necessary); role-play the application of this process to a family issue of conflict. |
| 19. Verbalize a resolution of irrational guilt feelings related to the death. (29, 30) | 29. Dispute the caregivers' or siblings' unreasonable sense of guilt over the death, exploring and replacing irrational thoughts with realistic thoughts. |
| | 30. Explore caregiver's and sibling's regrets by asking about what they believe could have, should have, or if only had been done. |
| 20. Express thoughts and feelings that were disappointedly left unexpressed to the deceased. (31) | 31. Explore with the caregivers and siblings what they wish had been said to the deceased before the death. Utilize the empty chair technique to facilitate this discussion. Assign the caregivers and siblings to write a letter to the child, saying good-bye. Process the reactions to the assignment. |
| 21. Decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the child's death. (32) | 32. Assess the caregivers and siblings for increased use of alcohol and other mood-altering substances following the event that are used as a means of coping with the death; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary. |
| 22. Maintain focus on the present rather than the past or future. (33) | 33. Acknowledge the desire for answers, but redirect caregivers and siblings from focusing on *why* questions to identify the affect behind the questions. |
| 23. Openly share memories of the child. (34, 35) | 34. Conduct family sessions in which all members share their |

memories of the child and their emotional reactions to the death. Use of yearbooks, photo albums, and awards may facilitate this process.

35. Encourage the caregivers and siblings to talk to the deceased child, share their dreams, and say good-bye; utilize the empty chair technique.

24. Restore routine daily activities in a timely manner. (36, 37)

36. Educate the caregivers and siblings about the important of maintaining adequate eating, personal hygiene habits, and healthy sleeping patterns. Suggest ways to maintain these through use of journaling and relaxation techniques.

37. Suggest a time-limited period be set aside each day for the caregivers and siblings to focus on the loss (e.g., 20 minutes in the morning); after the time is completed, they will engage in typical daily activities.

25. Use popular media such as books and DVDs to better understand the grief experience and increase a sense of hope. (38)

38. Assign the caregivers and siblings to read books on grief (e.g., *Good Grief* by Westberg, *How to Go on Living When Someone You Love Dies* by Rando) or watch DVDs (e.g., *Ordinary People, My Girl*) that focus on grieving. Discuss with the caregivers(s) and sibling(s) how those characters coped with loss and expressed their grief.

26. Begin the process of disposing of the child's belongings. (39)

39. Discuss the caregiver's and sibling's need to clean the deceased's room, take care of belongings, distribute clothes, and so on; recommend this process to be gradual to avoid feeling overwhelmed or

regretting decisions that cannot be reversed.

27. Connect with community-based resources that can provide grief support. (40)

40. Direct the caregivers and siblings to community-based services (e.g., faith-based institutions, SIDS support groups in community or online, Compassionate Friends, etc.) that can provide support and encouragement throughout the grieving process.

28. Cooperate with completing objective assessment instruments regarding the adjustment to the child's death. (41, 42)

41. Administer to the caregivers and/or siblings assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Symptom Checklist–90–Revised, Trauma Symptom Checklist, Traumatic Life Events Questionnaire, Family Crisis Oriented Personal Evaluation Scales [F-COPE], Beck Depression Inventory–II) to monitor the recovery process.

42. Conduct suicide and homicide assessments with the caregivers and siblings as needed.

29. Agree to contact mental health providers if grief-related problems interfere with daily functioning. (43, 44, 45)

43. Educate the caregivers and siblings about possible psychological complications (e.g., flashbacks, depression, suicidal ideations) to the traumatic death that would require additional intervention.

44. Provide lists of available mental health referral and self-help resources to the caregivers and siblings.

45. Provide to the caregivers and siblings pamphlets and other literature regarding grief and bereavement.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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# MISCARRIAGE / STILLBIRTH / ABORTION

## BEHAVIORAL DEFINITIONS

1. Spontaneous termination of pregnancy by natural causes (i.e., miscarriage/stillbirth).
2. Medically induced termination of pregnancy (i.e., abortion).
3. Experiencing grief reactions (e.g., a sense of loss, emptiness, restlessness, helplessness, hopelessness, poor concentration, depression, decreased social interactions, anger).
4. Self-blame or inappropriately blaming medical staff for the miscarriage/stillbirth.
5. A sense of guilt and regret following an elective abortion.

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## LONG-TERM GOALS

1. Begin a healthy grieving process around the loss.
2. Accept the loss realistically by letting go of the need to define why the termination of the pregnancy occurred.
3. Return to the previous level of social, emotional, and physical functioning.
4. Develop a sense of peace for the decision to abort child.

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## SHORT-TERM OBJECTIVES

1. Receive appropriate medical care. (1)

2. Actively participate in the discussions regarding disposition of the aborted infant (medical procedures, seeing/holding the child, burial/memorial arrangements). (2, 3, 4)

3. Describe the feelings that were experienced at the time of the death (miscarriage/stillborn/abortion) and how those have

## THERAPEUTIC INTERVENTIONS

1. Assist in getting the client to his/her physician, urgent care, or emergency department for a medical evaluation.

2. Consult privately with medical staff (if possible) about procedures followed at their agency regarding miscarriages/stillbirths, disposition of the fetus, and medical treatment options the client may need to address. Educate and prepare the client for what to expect; process the client's emotions; provide supportive and encouraging feedback regarding active involvement in decision-making.

3. Encourage the client to look at the ultrasound prints or hold, talk to, verbalize dreams, and say good-bye to the child; monitor and process emotions while also respecting the need for privacy.

4. Encourage the client to actively participate in funeral/memorial plans.

5. Offer relational caregiving that underscores the uniqueness of each client through consistent eye contact, unconditional

impacted daily functioning since its occurrence. (5, 6, 7, 8)

positive regard, and warm acceptance to explore the client's emotional reaction at the time of the loss.

6. Assist the client in developing ways to effectively communicate to others the end of the pregnancy/death of the child; use rehearsal, role-playing, and role reversal for success.
7. Assign the client to keep a daily journal of maladaptive automatic thoughts associated with grieving; process the negative thought journal material identifying positive, reality-based thought alternatives (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).
8. Encourage the client to name the child. Explore why that name had been chosen, what future plans were imagined for the child, and what preparations had already taken place to bring the child home; empathize with the lost dreams/plans.

4. Complete screening tools to identify severity of depressed mood/grief reactions. (9, 10)

9. Assess the client's frequency and intensity of grief/loss reactions or depressed mood on his/her emotional, cognitive, and behavioral functioning using an objective instrument (e.g., Symptom Checklist–90–Revised; Beck Depression Inventory–II; or Edinburgh Postnatal Depression Scale).
10. Refer the client to a physician or psychiatrist to assess the need for psychotropic medication, and

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| | order a prescription, if appropriate. Obtain a release of information to confer regularly with the prescribing physician or psychiatrist; monitor client's psychotropic medication compliance, side effects, and effectiveness. |
| 5. Verbalize an understanding of distorted cognitive messages regarding the cause of the death that promote anger or hopelessness and its treatment. (11, 12, 13) | 11. Obtain a release of information from the client to appropriate health care professionals for course of treatment rendered; review factual details of the treatment with the client, redirecting any misplaced anger or blame away from self or health care providers. |
| | 12. Discuss facts of the miscarriage/ stillbirth with the client to explore distorted cognitive messages that intensify the negative emotional reactions to the loss. |
| | 13. Encourage the client to explore the criteria from her physician for both physical and emotional readiness for attempting future pregnancies; including viability of future pregnancies. Identify any questions and/or misgivings regarding future pregnancies. Monitor compliance in obtaining information and process for a realistic understanding of the information. |
| 6. Verbalize an increased understanding of the steps in the grief process. (14, 15, 16) | 14. Educate the client on the stages of grieving and answer any questions; reassure the client that grief is personal and that everyone differs in the way they process grief. |
| | 15. Assist the client in obtaining mementos of child (e.g., a lock of hair, a set of footprints, a birth certificate, a picture of the child, |

the plastic arm identification band from the hospital, fetal monitoring device paper, a print of the sonogram, or a record of the child's weight, length, head and chest measurements). Identify ways to preserve mementos (e.g., photo albums, photo box, storage box, laminating items; write on a piece of paper what each item is actually of/from).

16. Assist the client in identifying ways memories planned for or of the child can be preserved through means such as writing a letter to the deceased fetus or child saying good-bye, journaling, or scrap-booking (or assign "Creating A Memorial Collage" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); reinforce success.

7. Verbalize any unresolved grief issues that may be contributing to guilt, depression, helplessness, or anger. (17, 18, 19)

17. Assist the client in identifying and expressing feelings connected with the loss (e.g., use of cognitive behavioral therapy interventions, use of a thought record).

18. Explore with the client the role of unresolved grief issues as they contribute to the client's current depression (see "Grief/Loss Unresolved" chapter in *The Complete Adult Psychotherapy Treatment Planner,* 4th ed. by Jongsma, Peterson, and Bruce).

19. Educate the client that keeping feelings pent up has the potential of strengthening the emotions and their becoming more destructive with time; review with the client how articulating negative emotions can positively move them through the culturally accepted grief process.

8. Identify and replace blaming thoughts with positive, realistic, accepting self-talk. (20, 21, 22)

20. Educate the client how his/her feeling helpless, frustrated, or angry is perpetuated out of not having answers to why the loss occurred; identify how accepting not having an answer to why the loss occurred is the final stage of the grieving process.

21. Ask the client to share the progression of her pregnancy and ways she cared for herself and the fetus; highlight the lack of connection between her behavior and the miscarriage/stillbirth.

22. Assess if the client is blaming herself or others for the loss; confront and challenge any of the client's misdirected anger (on self, to medical personnel, toward God) with reality-based alternatives; review and reinforce success in sessions, providing corrective feedback for failure.

9. Implement behavioral strategies to reduce emotional distress. (23, 24)

23. Assist the client in developing coping strategies (e.g., journaling, meditation, getting enough sleep, exercise, balanced diet) for reducing emotional distress; reinforce success.

24. Recommend that the client read and implement programs from *Exercising Your Way to Better Mental Health* by Leith.

10. Identify individuals that will offer support in times of distress (25, 26, 27)

25. Engage the client in drawing an eco-map to identify people whom the client can rely upon for support; review eco-map, encouraging the client to have frequent communication with supportive people.

26. Offer a family or group therapy session to identify supportive family and friends; validate the

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| | family members'/friends' emotions of grief/loss; educate family/friends on ways they can help the client cope with the loss (e.g., active listening, being nonjudgmental, avoiding clichés, physical comfort, allowing time to grieve at her own pace). |
| | 27. Inquire about the client's religious/ spiritual beliefs and encourage him/her to use this resource for support; reinforce the client's use of faith as a source of comfort, not a source or *cause* of the miscarriage/ stillbirth; monitor frequency of contact and compliance in contacting. |
| 11. Maintain involvement in social and vocational activities, assimilating the traumatic event into daily living. (28) | 28. Encourage the client to return to work, social engagements, and/or daily routines that occurred prior to the loss; phase these activities into daily living gradually, but steadily, if necessary. |
| 12. Learn and implement relapse prevention strategies for emotional reactions on the projected due date or the anniversary day of the death. (29, 30, 31) | 29. Utilize stress inoculation training including such aspects as psychoeducation, calming and coping skills training, assertiveness skill training, and guided self-dialogue (see *Stress Inoculation Training* by Meichenbaum) to help the client prepare in advance for the re-emergence of grief reactions during anniversaries or other important dates. |
| | 30. Identify and rehearse with the client the management of increased emotional reactions associated with future situations or circumstances (e.g., loss anniversary date, projected due date). |

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| | 31. Prompt the client to talk about how the negative emotional reactions to the loss have increased with the approaching anniversary of the loss or other future major life events (e.g., holidays, baby's "first" life experiences, graduation, birth of siblings, etc.). Design an activity to be implemented on that day; process the completed assignment. |
| 13. Read books on positive ways to cope following a miscarriage or stillbirth. (32) | 32. Recommend that the client read self-help books on coping with grief and miscarriage/stillbirths (e.g., *Empty Arms: Coping After Miscarriage, Stillbirth and Infant Death* by Ilse; *The Bereaved Parent* by Schiff; *On Death and Dying* by Kübler-Ross). |
| 14. Participate in a support group for people who experienced a miscarriage or stillborn pregnancy. (33) | 33. Refer the client to a support group that is focused on parents who have experienced a miscarriage or stillbirth; encourage the client to share his/her experience of the loss and its effects on them with others in the group. |
| 15. Describe the factors that led to the abortion decision. (34, 35) | 34. Ask the client to make a list of the factors that contributed to the abortion decision; process the list content. |
| | 35. Encourage the client to share feelings of guilt or ambivalence related to the abortion decision in order to clarify them and gain insight into decision-making. |
| 16. Identify the benefits of forgiveness. (36, 37) | 36. Explore with the client people she feels influenced (or pressured) her decision to abort and how forgiveness can benefit those relationships; teach steps of the forgiveness process; reinforce success. |

37. Recommend that the client read self-help books on forgiveness (e.g., *The Art of Forgiving* by Smedes or *Forgiveness Is a Choice: A Step-by-Step Process for Resolving Anger and Restoring Hope* by Enright); process material read.

17. Verbalize hopeful and positive statements regarding the future. (38, 39)

38. Assign the client to write at least one positive affirmation statement daily regarding herself and the future.

39. Identify grief as a process; reminding the client there will be various intensities of emotions over the course of time, and at times unexpectedly; validate the normalcy in variation of feelings; develop a plan for coping with those emotions (e.g., journaling, not isolating, exercise, open communication with support systems, prayer).

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 301.6 | F60.7 | Dependent Personality Disorder |
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# PHOBIAS

## BEHAVIORAL DEFINITIONS

1. A persistent and unreasonable fear of a specific object or situation that promotes avoidance behaviors because an encounter, confronted and/or contemplated, with the phobic stimulus provokes a subjective experience of intense anxiety (without evidence of a panic disorder).
2. Avoids the phobic stimulus/feared environment or endures it with distress, resulting in interference of normal routines.
3. Physical symptoms of nausea, excessive perspiration, shallow breathing, and/or accelerated heart rate occur when confronting the feared object or situation.
4. The phobic fear has developed after experiencing a severe trauma related to the stimulus object or situation.

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## LONG-TERM GOALS

1. Reduce fear of the specific stimulus object or situation that previously provoked phobic anxiety.
2. Reduce phobic avoidance of the specific object or situation, leading to comfort and independence in moving around in a public environment.
3. Develop strategies to induce calm when experiencing anxiety, fear, restlessness, and so forth.
4. Eliminate interference in normal routines and remove distress from feared object or situation.

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## SHORT-TERM OBJECTIVES

1. Describe the history and nature of the phobia(s), including any traumatic event that is associated with the onset of phobia(s), complete with impact on functioning and attempt to overcome it. (1, 2)

2. Identify any medical problems that may contribute to impairment or inhibit treatment, and receive adequate medical attention. (3)

3. Cooperate with an evaluation by a physician or psychiatrist for psychotropic medication. (4, 5)

## THERAPEUTIC INTERVENTIONS

1. Explore and identify the objects or situations that precipitate the client's phobic fear, including past or present traumatic events.

2. Assess the client's fear and avoidance, including the focus of fear, types of avoidance (e.g., distraction, escape, dependence on others), development, and disability (e.g., Anxiety Disorders Interview Schedule for DSM-5: Client Interview Schedule).

3. Refer the client to a physician to identify and treat any medical conditions that may be contributing to anxiety (e.g., hypoglycemia, drug intoxication/withdrawal, parathyroid disease, etc.).

4. Arrange for an evaluation for a prescription of psychotropic medication if the client requests it or if the client is likely to be noncompliant with gradual exposure.

5. Obtain a release of information to confer regularly with the prescribing physician or psychiatrist; monitor the client's

psychotropic medication compliance, side effects, and overall effectiveness of the medication.

4. Provide honest and complete information for a chemical dependence biopsychosocial history; including use of any substances that may be contributing to anxiety symptoms. (6, 7, 8, 9)

6. Assess the client for the presence of chemical dependence; refrain from treating the phobia until abstinence has been achieved.
7. Use the biospychosocial history to help the client understand the familial, emotional, and social factors that contributed to the development of chemical dependence.
8. Refer the client for treatment for chemical dependence and/or 12-step group to establish and maintain sobriety.
9. Educate the client on the importance of avoiding stimulants (e.g., caffeine, nicotine, various over-the-counter products) because of their stimulation effect on the central nervous system; monitor compliance in avoiding intake/use of stimulants.

5. Verbalize an accurate understanding of information about phobias and their treatment. (10, 11, 12, 13)

10. Discuss how phobias are very common, a natural but irrational expression of our fight or flight response, and are not a sign of weakness, but cause unnecessary distress and disability.
11. Discuss how phobic fear is maintained by a "phobic cycle" of unwarranted fear and avoidance that precludes positive, corrective experiences with the feared object or situation, and how treatment breaks the cycle by encouraging these experiences (see *Mastering Your Fears and Phobias: Workbook* by Antony, Craske, and

Barlow; *Overcoming Specific Phobia—Therapist Protocol: A Hierarchy & Exposure-Based Protocol for the Treatment of All Specific Phobias* by Bourne). EB

12. Assign the client to read psychoeducational chapters of books or treatment manuals on specific phobias (e.g. *Mastering Your Fears and Phobias: Workbook* by Antony, Craske, and Barlow; *The Anxiety and Phobia Workbook,* 5th ed. by Bourne; *Living With Fear: Understanding and Coping With Anxiety* by Marks). EB

13. Inquire if anxiety symptoms are consistent with a panic attack and/or anxiety attack; address accordingly. EB

EB 6. Verbalize an understanding of the cognitive, physiological, and behavioral components of anxiety and its treatment. (14, 15, 16)

14. Discuss how phobias involve perceiving unrealistic threats, bodily expressions of fear, and avoidance of what is threatening, which interact to maintain the problem (see *Mastering Your Fears and Phobias: Workbook* by Antony, Craske, and Barlow; *Overcoming Specific Phobia—Therapist Protocol: A Hierarchy & Exposure-Based Protocol for the Treatment of All Specific Phobias* by Bourne). EB

15. Discuss how exposure serves as an arena to desensitize learned fear, build confidence, and feel safer by building a new history of successful experiences (see *Mastering Your Fears and Phobias: Workbook* by Antony, Craske, and Barlow; *Overcoming Specific Phobia—Therapist Protocol: A Hierarchy & Exposure-Based Protocol for the*

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| | *Treatment of All Specific Phobias* by Bourne). |
| | 16. Assign the client a homework exercise of writing a list of his/her physical, emotional, and behavioral reactions when thinking about and/or confronting the phobic situation; review the list in session providing corrective feedback to each reaction identified. |
| 7. Learn and implement calming skills to reduce and manage anxiety symptoms that may emerge during encounters with phobic object or situations. (17, 18) | 17. Teach the client anxiety management skills (e.g., staying focused on behavioral goals, progressive muscle relaxation, deep rhythmic breathing, meditation, positive self-talk) to address anxiety symptoms that may emerge during encounters with phobic objects or situations; assign daily practice of a skill. |
| | 18. Utilize biofeedback techniques to facilitate the client learning relaxation skills; monitor compliance and effectiveness while providing corrective feedback toward improvement. |
| 8. Cooperate with acupuncture treatment related to phobic reaction. (19) | 19. Refer the client for acupuncture to relieve symptoms of stress; review success. |
| 9. Cooperate with eye movement desensitization and reprocessing (EMDR) technique to reduce emotional reactions to phobic object or situation. (20) | 20. Utilize the EMDR exposure technique to reduce the client's anxiety associated with the phobic stimulus. |
| 10. Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk. (21, 22, 23) | 21. Explore the client's schema and self-talk that mediate his/her fear response; challenge the biases; assist him/her in replacing the distorted messages with reality-based, positive self-talk. |

22. Assign the client a homework exercise in which he/she journals times when anxiety responses are successfully managed between sessions and when he/she identifies fearful self-talk and creates reality-based alternatives (see "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); review and reinforce success, providing corrective feedback for failure.

23. Teach the client how to use an automatic thought record (see *I Want to Change My Life: How to Overcome Anxiety, Depression and Addiction* by Melemis) to identify and track distorted cognitions; challenge the client to replace the negative self-talk with positive, empowering self-talk.

11. Undergo repeated exposure to feared or avoided phobic objects or situations. (24, 25, 26)

24. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with the phobic response.

25. Select initial exposures that have a high likelihood of being a successful experience for the client; develop a plan for managing the symptoms and rehearse the plan.

26. Assign the client a homework exercise in which he/she does situational exposures and record responses (see "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma; *Mastering Your Fears and Phobias: Workbook* by Antony, Craske, and Barlow;

*Living With Fear: Understanding and Coping With Anxiety* by Marks); review and reinforce success or provide corrective feedback toward improvement.

12. Implement relapse prevention strategies for managing possible future anxiety symptoms when confronted or contemplate confrontation with phobic object or situation. (27, 28, 29, 30)

27. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a temporary and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.

28. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

29. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, exposure), building them into his/her life as much as possible.

30. Develop a "coping card" on which coping strategies and other important information (e.g., "You're safe," "Pace your breathing," "Focus on the task at hand," "You can manage it," "Stay in the situation," and "Let the anxiety pass") are written for the client's later use.

13. Verbalize the costs and benefits of remaining fearful and avoidant. (31)

31. Probe for the presence of secondary gain that reinforces the client's phobic actions through escape or avoidance mechanisms.

14. Verbalize the separate realities of the irrationally feared object or situation and the emotionally painful experience from the past that has been evoked by the phobic stimulus. (32, 33)

32. Clarify and differentiate between the client's current irrational fear and past emotional pain.

33. Encourage the client's sharing of feeling associated with past

trauma through active listening, positive regard, and questioning.

15. Commit self to not allowing phobic fear to take control of life and lead to a consistent avoidance of normal responsibilities and activities. (34, 35)

34. Support the client in following through with work, family, and social activities rather than escaping or avoiding them.

35. Ask the client to list several ways his/her life will be more satisfying or fulfilling as he/she manages his/her symptoms of panic and continues normal responsibilities.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 309.24 | F43.22 | Adjustment Disorder, With Anxiety |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 300.21 | F40.00 | Agoraphobia |
| 300.01 | F41.0 | Panic Disorder |
| 300.23 | F40.10 | Social Anxiety Disorder (Social Phobia) |
| 300.29 | F40.xxx | Specific Phobia |
| 301.82 | F60.6 | Avoidant Personality Disorder |
| 301.83 | F60.3 | Borderline Personality Disorder |
| 301.50 | F60.4 | Histrionic Personality Disorder |
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# POSTTRAUMATIC STRESS DISORDER (PTSD)[1]

## BEHAVIORAL DEFINITIONS

1. Exposure to actual or threatened death or serious injury that resulted in an intense emotional response of fear, helplessness, or horror.
2. Intense emotional distress when exposed to reminders of the traumatic event.
3. Physiological reactivity when exposed to internal or external cues that symbolize the traumatic event.
4. Recurrent and intrusive recollections of the event including images, thoughts, dreams, or perceptions.
5. Acting and feeling as if the event was reoccurring.
6. Inability to recall important aspects of the trauma.
7. Avoidance of activities, places, people, thoughts, feelings, or conversations about the traumatic event.
8. Lack of interest and participation in significant activities.
9. Inability to experience the full range of emotions, including love.
10. A pessimistic, fatalistic attitude regarding the future.
11. Feeling of detachment or estrangement from others.
12. Sleep disturbances and/or disturbing dreams associated with the traumatic event.
13. Lack of concentration.
14. Hypervigilance, exaggerated startle response.
15. Irritability or outbursts of anger.
16. Sad or guilty affect and other signs of depression, including suicidal thoughts.
17. Alcohol and/or drug abuse.

[1]Much of the content of this chapter (with only slight revisions) originates from A. E. Jongsma, Jr., L. M. Peterson, and T. J. Bruce, *The Complete Adult Psychotherapy Treatment Planner*, 4th ed. (Hoboken, NJ: John Wiley & Sons, 2006). Copyright © 2006 by A. E. Jongsma, Jr., L. M. Peterson, and T. J. Bruce. Reprinted with permission.

18. A pattern of interpersonal conflict, especially in intimate relationships.
19. Inability to maintain employment or frequent changes in employment due to supervisor/coworker conflict or anxiety symptoms.

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## LONG-TERM GOALS

1. Reduce the negative impact that the traumatic event has had on many aspects of life and return to the pre-trauma level of functioning.
2. Develop and implement effective coping skills to carry out normal responsibilities and participate constructively in relationships.
3. Diminish intrusive images and the alteration in functioning or activity level that is due to stimuli associated with the trauma.
4. Terminate the destructive behaviors that serve to maintain escape and denial while implementing behaviors that promote healing, acceptance of the past events, and responsible living.

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## SHORT-TERM OBJECTIVES

1. Describe the history and nature of PTSD symptoms. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the client's frequency, intensity, duration, and history of PTSD symptoms and their

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| | impact on functioning (or assign "How the Trauma Affects Me" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma; see also Anxiety Disorders Interview Schedule for *DSM-5:* Client Interview Schedule). |
| 2. Complete psychological testing to assess and/or track the nature and severity of PTSD symptoms. (3) | 3. Administer or refer the client for administration of psychological testing to assess for the presence and strength of PTSD symptoms (e.g., Minnesota Multiphasic Personality Inventory–2 Restructured Form [MMPI-2 RF]; Impact of Event Scale, Revised; Modified PTSD Symptom Scale [MPSS-SR]; Trauma Symptom Inventory–2). |
| 3. Describe the traumatic event, providing as much detail as possible. (4) | 4. Gently and sensitively explore the client's recollection of the facts of the traumatic incident and his/her emotional reactions at the time (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| 4. Cooperate with a medical assessment for physical symptoms that have begun since the traumatic event. (5) | 5. Refer the client to his/her physician, urgent care, or emergency department for a medical evaluation; monitor the client's compliance with the assessment and treatment recommendations. |
| 5. Verbalize symptoms of depression, including any suicidal ideation. (6) | 6. Assess the client's depth of depression and suicide potential and treat appropriately, taking the necessary safety precautions as indicated (see the Depression and Suicidal Ideation chapters in *The Complete Adult Psychotherapy Treatment Planner,* 4th ed. by Jongsma, Peterson, and Bruce). |

6. Provide honest and complete information for a chemical dependence biopsychosocial history. (7, 8, 9)

7. Assess the client for the presence of chemical dependence associated with the trauma.

8. Use the biospychosocial history to help the client understand the familial, emotional, and social factors that contributed to the development of chemical dependence.

9. Refer the client for treatment for chemical dependence (see the Chemical Dependence chapter in *The Complete Adult Psychotherapy Treatment Planner,* 4th ed. by Jongsma, Peterson, and Bruce).

7. Cooperate with an evaluation by a physician for psychotropic medication. (10, 11)

10. Assess the client's need for medication (e.g., selective serotonin reuptake inhibitors) and arrange for prescription, if appropriate.

11. Obtain a release of information from the client to allow for regular consultation with the prescribing physician; monitor the client's psychotropic medication compliance, side effects, and effectiveness on his/her level of functioning.

8. Verbalize an accurate understanding of PTSD and how daily functioning has been impacted. (12, 13)

12. Discuss how PTSD results from exposure to trauma, resulting in intrusive recollections, unwarranted fears, anxiety, and a vulnerability to other negative emotions such as shame, anger, and guilt.

13. Assign the client to read psychoeducational chapters of books or treatment manuals on PTSD that explain its features and development (e.g., *Coping With Trauma: Hope Through Understanding* by Allen).

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| 9. Verbalize an understanding of distorted cognitive messages that promote fear, worry, or anxiety and its treatment. (14, 15) | 14. Discuss how coping skills, cognitive restructuring, and exposure help build confidence, desensitize and overcome fears, and see one's self, others, and the work in a less fearful and/or depressing way. |
| | 15. Assign the client to read about stress inoculation, cognitive restructuring, and/or exposure-based therapy in chapters of books or treatment manuals on PTSD (e.g., *Reclaiming Your Life After Rape: Cognitive-Behavioral Therapy for Posttraumatic Stress Disorder Client Workbook* by Rothbaum and Foa; *I Can't Get Over It: A Handbook for Trauma Survivors* by Matsakis). |
| 10. Learn and implement calming and coping strategies to manage challenging situations related to trauma. (16) | 16. Teach the client strategies from stress inoculation training such as relaxation, breathing control, covert modeling (e.g., imagining the successful use of the strategies) and/or role-playing (e.g., with therapist or trusted other) for managing fears until a sense of mastery is evident (see *Stress Management: A Comprehensive Handbook of Techniques and Strategies* by Smith). |
| 11. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (17, 18) | 17. Explore the client's schema and self-talk that mediates trauma-related fears; challenge negative biases and assist him/her in generating appraisals that correct for the biases and build confidence. |
| | 18. Assign the client a homework exercise in which she/he identifies fearful self-talk and creates reality-based alternatives; review |

and reinforce success, providing corrective feedback for failure (see "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma; *Reclaiming Your Life After Rape: Cognitive-Behavioral Therapy for Posttraumatic Stress Disorder Client Workbook* by Rothbaum and Foa).

12. Participate in imaginal and *in vivo* exposure to trauma-related memories until talking or thinking about the trauma does not cause marked distress. (19, 20, 21)

19. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with the phobic response.

20. Have the client undergo imaginal exposure to the trauma by having him/her describe a traumatic experience at an increasing, but client-chosen level of detail; repeat until associated anxiety reduces and stabilizes. Record the session; have the client listen to it between sessions (see *Handbook of PTSD: Science and Practice* by Freidman, Keane, and Resick); review and reinforce progress, problem solving obstacles.

21. Assign the client a homework exercise in which he/she does an exposure exercise and records responses (see "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma; *Handbook of PTSD: Science and Practice* by Freidman, Keane, and Resick); review and reinforce progress, problem solving obstacles.

13. Learn and implement thought-stopping to manage intrusive unwanted thoughts. (22)

22. Teach the client thought-stopping, in which he/she internally voices the word *STOP* and/or imagines something representing the concept of stopping (e.g., a stop sign or light) immediately upon noticing unwanted trauma or otherwise negative unwanted thoughts (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

14. Learn and implement guided self-dialogue to manage thoughts, feelings, and urges brought on by encounters with trauma-related stimuli. (23)

23. Teach the client a guided self-dialogue procedure in which he/she learns to recognize maladaptive self-talk, challenge its biases, cope with engendered feelings, overcome avoidance, and reinforce his/her accomplishments (see *Handbook of PTSD: Science and Practice* by Freidman, Keane, and Resick); review and reinforce progress, problem solving obstacles.

15. Learn and implement relapse prevention strategies for managing possible future trauma-related symptoms. (24, 25, 26, 27)

24. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.

25. Identify and rehearse with the client the management of future situations or circumstances (e.g., event anniversary date, holidays, etc.) in which lapses could occur.

26. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring,

social skills, and exposure) while building social interactions and relationships.

27. Assist the client in developing a "coping card" on which behavioral and cognitive strategies and other important information can be kept (e.g., steps in problem solving, positive coping statements, reminders that were helpful to the client during therapy).

16. Cooperate with eye movement desensitization and reprocessing (EMDR) technique to reduce emotional reactions to the traumatic event. (28)

28. Utilize the EMDR exposure technique to reduce the client's emotional reactivity to the traumatic event.

17. Acknowledge the need to implement anger control techniques; learn and implement anger management techniques. (29, 30)

29. Assess the client for instances of poor anger management that have led to threats or actual violence that caused damage to property and/or injury to people.

30. Teach the client anger management techniques (see the Anger Management chapter in *The Complete Adult Psychotherapy Treatment Planner,* 4th ed. by Jongsma, Peterson, and Bruce; *The Anger Management Sourcebook* by Schiraldi and Kerr; *The Angry Book* by Rubin).

18. Implement a regular exercise regimen as a stress release technique. (31)

31. Develop and reinforce a routine of physical exercise for the client (see *Exercising Your Way to Better Mental Health* by Leith).

19. Sleep without being disturbed by dreams of the trauma. (32)

32. Monitor the client's sleep patterns and encourage use of relaxation, positive imagery, and sleep hygiene as aids to sleep (see the Sleep Disturbance chapter in *The Complete Adult Psychotherapy Treatment*

*Planner,* 4th ed. by Jongsma, Peterson, and Bruce).

20. Identify individuals that will offer support in times of distress. (33, 34)

33. Engage the client in drawing an eco-map to identify people whom the client can rely upon for support; review the eco-map, encouraging the client to have frequent communication with supportive people.

34. Conduct family and conjoint sessions to facilitate healing of hurt caused by the client's symptoms of PTSD.

21. Participate in group therapy session focused on PTSD. (35)

35. Refer the client to or conduct group therapy sessions where the focus is on sharing traumatic events and their effects with other PTSD survivors.

22. Verbalize an understanding of the negative impact PTSD has had on vocational functioning. (36, 37)

36. Explore the client's vocational history and treat his/her vocational issues as appropriate (see the Vocational Stress chapter in *The Complete Adult Psychotherapy Treatment Planner,* 4th ed. by Jongsma, Peterson, and Bruce).

37. Inquire about possible secondary gain reasons that the client might want to obtain a diagnosis of PTSD (e.g., gaining veteran's disability benefits, worker's compensation, Social Security disability, etc.).

23. Identify and participate in a ritual that reinforces putting the traumatic event in the past. (38)

38. Encourage the client to participate in a ritual that assists him/her with a positive assimilation of the past traumatic event into their current activities of daily living (e.g., visit the Vietnam Veterans Memorial Wall, the Holocaust Museum, gravesite, etc.).

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 296.xx | F31.xx | Bipolar I Disorder |
| 300.6 | F48.1 | Depersonalization/Derealization Disorder |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 296.xx | F33.x | Major Depressive Disorder, Recurrent Episode |
| V65.2 | Z76.5 | Malingering |
| 295.70 | F25.0 | Schizoaffective Disorder, Bipolar Type |
| 295.70 | F25.1 | Schizoaffective Disorder, Depressive Type |
| 301.7 | F60.2 | Antisocial Personality Disorder |
| 301.82 | F60.6 | Avoidant Personality Disorder |
| 301.83 | F60.3 | Borderline Personality Disorder |
| 301.50 | F60.4 | Histrionic Personality Disorder |
| 301.9 | F60.9 | Unspecified Personality Disorder |
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# SCHOOL TRAUMA (COLLEGE)

## BEHAVIORAL DEFINITIONS

1. The traumatic, sudden death or serious injury of student(s), residence hall professionals, faculty members, or support staff (e.g., due to suicide, motor vehicle accident, residence hall accident or fire, natural disaster, explosion, etc.).
2. Invasion of campus by one or more persons carrying lethal weapons who threaten and/or murder students, faculty members, or other college personnel.
3. Sudden death of student while participating in a school-supported activity such as athletic or social event.
4. Stalking, kidnapping, or sexual assault on or near the college campus of student, faculty member, or support staff.
5. Pandemic that results in severe illness and/or death of students, faculty members, and/or staff.
6. Dramatic structural damage to residence hall, multi-student facility, or academic building caused by fire, explosion, bomb threat, chemical spill, or natural disaster (e.g., tornado, hurricane, flood, earthquake).
7. Unknown person(s) threatens violence to anyone in the vicinity of or on campus.
8. Increased use of alcohol or other mood-altering substances following a traumatic event.
9. Persistent fear of death or personal injury occurring to self.
10. Social withdrawal and isolation; avoidance of certain locations/building on college campus.
11. Inability to regulate emotions following the event.
12. Feelings of guilt regarding having been a survivor of a crisis or trauma in which others died
13. Disruption of typical sleep patterns following a traumatic event.
14. Preoccupation or disclosure of suicidal or homicidal ideations.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore appropriate levels of behavioral and emotional functioning.
3. Re-establish a sense of meaning for the future.
4. Return of a sense of safety to the students, faculty, and staff.
5. Re-establish healthy, age-appropriate relationships.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
|---|---|
| 1. College officials ensure the physical safety of all students. (1, 2) | 1. Direct college officials to move the students to a safe location, which might vary depending on the situation.<br>2. Direct college officials to get medical attention to injured students. |
| 2. College officials identify and account for all students and report missing students. (3) | 3. Ask the college officials to use residence hall directories and class rosters to identify and locate unaccounted-for students. |

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| 3. Students reunite with or contact caregivers as soon as possible. (4, 5, 6, 7, 8) | 4. Develop a list of students' locations to facilitate communication with the caregivers. |
| | 5. Contact the caregivers as soon as possible following the event to give them information about their student; this may involve activating an automatic communication system. |
| | 6. Directly contact the caregivers of students who have been injured to notify them of the trauma and give directions regarding where to meet their student. |
| | 7. Set up quiet, private or semi-private locations where the students and caregivers can reunite. |
| | 8. Provide refreshments and communication (i.e., phones, computers) for the students and caregivers. |
| 4. College officials provide accurate and appropriate information in a timely manner. (9) | 9. Assist the administration in crafting factual information to disseminate to students, caregivers, college personnel, and the community regarding the event as permitted. |
| 5. Students demonstrate a calm demeanor. (10, 11, 12) | 10. Reassure the students of their safety and use active listening skills to attend to students' and caregivers' questions. |
| | 11. Place limits on students' behaviors that are potentially self-destructive. |
| | 12. Provide quiet rooms for students to use to calm themselves. |
| 6. Students engage in behaviors that promote safety. (13) | 13. Use role-play situations to promote safe behaviors by the students (e.g., conflict resolution, mediation skills). |

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| 7. Students express a realistic appraisal of the traumatic event. (14) | 14. Help the students gain a realistic perspective of the event using appropriate language (e.g., reassure students that they are not to blame for event, injuries, or deaths, if these occurred). |
| 8. Students cooperate with an assessment for affective, behavioral, and cognitive reactions to the event. (15) | 15. Administer to the students assessment instruments that are specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Triage Assessment Scale for Students in Learning Environments [TASSLE], Traumatic Events Screening Inventory [TESI - SRR], Symptom Checklist-90–Revised, Trauma Symptom Checklist) to guide treatment that is needed. |
| 9. Students explore and express their feelings about and perception of the event. (16, 17, 18, 19) | 16. Use art therapy to explore and allow the students' expression of affective, behavioral, and cognitive reactions to the event. |
| | 17. Use active listening skills to explore the students' affective, behavioral, and cognitive reactions while they recount the trauma in as much detail as they are comfortable with (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| | 18. Allow and facilitate a controlled expression of feelings by placing limits, allowing them to be articulated in a safe, non-threatening manner. |
| | 19. Encourage and facilitate the students sharing affective, behavioral, and cognitive reaction with a professional |

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| | therapist, family member, and/or trusted friend. |
| 10. Students engage in positive self-talk and problem solving to build confidence and overcome feelings of anxiety. (20, 21, 22) | 20. Confront the students' negative biases using cognitive behavioral techniques such as cognitive restructuring, in order to develop more positive, realistic thoughts about the event and maintain confidence about their safety. |
| | 21. Teach the students strategies from stress inoculation training such as relaxation, breathing control, covert modeling (e.g., imagining the successful use of the strategy), and/or role-playing (e.g., with a therapist or trusted friend) for managing fears until a sense of mastery is evident. |
| | 22. Use imaginal exposure to events about the trauma by having students describe the experience at an increasing but client-chosen level of detail; repeat until associated anxiety reduces and stabilizes; review and reinforce progress while using problem-solving skills to reduce obstacles. |
| 11. Students decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the event. (23) | 23. Assess the students for increased use of alcohol and other mood-altering substances following the event, which are used as a means of coping with the trauma; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary. |
| 12. Students engage in positive, healthy, constructive social interaction to prevent isolation and withdrawal and build self-esteem. (24, 25) | 24. Direct the students to campus programs that focus on prevention (e.g., suicide prevention hotlines, drug prevention programs, sexual assault prevention programs). |

25. Schedule structured activities (e.g., residence hall floor meetings, interest sessions regarding prevention programs, questions and answers sessions regarding the event) that facilitate students' interaction with others.

13. Students accept factual information regarding the drastic event and its consequences. (26)

26. If deaths occurred as a result of this event, discuss this while respecting cultural beliefs of students and caregivers.

14. Students identify previously healthy stress management strategies that can be implemented to reduce current affective distress. (27)

27. Explore the student's history of experiencing other traumatic events and determine healthy coping mechanisms used at that time; encourage the use of those strategies with the current incident.

15. Students identify positive consequences that may have resulted from the traumatic event. (28)

28. Use reframing to help the student identify and explore positive changes (e.g., closer family relationships, increased appreciation of future, revised values) that occur following a traumatic incident.

16. Students attend and participate in memorial rituals to the deceased. (29, 30)

29. Provide space for the students to memorialize the deceased in accordance with school policy.

30. Assist in planning a memorial service in honor of the deceased in which children, families, school personnel, and the community may take part.

17. Students return to typical daily routines. (31, 32, 33)

31. Educate the students about the importance of maintaining adequate eating and personal hygiene habits and help them plan ways to accomplish this.

32. Inquire about students' sleeping patterns and suggest strategies to help them achieve quality,

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| | refreshing sleep (e.g., journaling, relaxation techniques). |
| | 33. Educate the families on the importance of establishing typical daily routines to assist students in returning to normal functioning. |
| 18. Students maintain focus on the present rather than on the event. (34) | 34. Acknowledge the desire for answers, but redirect student(s) from focusing on *why* questions to identify the affect behind the questions. |
| 19. Caregivers use healthy communication skills in discussing the traumatic event. (35, 36) | 35. Offer intervention group sessions to allow the caregivers opportunities to express feeling and thoughts about the event. |
| | 36. Teach the caregivers to use healthy communication skills (e.g., owning feelings, not blaming, not minimizing feelings) to discuss the crisis or traumatic event. |
| 20. Staff and caregivers verbalize an understanding of common reactions to traumatic events. (37) | 37. Provide psycho-educational sessions for faculty, staff, and caregivers regarding typical reactions and poor recovery to crises or trauma. |
| 21. College officials revise safety plans and procedures. (38, 39) | 38. Assist the school in reviewing the implementation of a crisis plan (e.g., communicating with the caregivers, moving students to safety, writing notification memos, talking with media, involvement of outside agencies, relationship with law enforcement) in order to revise this. |
| | 39. Review and revise safety plans and communicate the changes to students and caregivers. |
| 22. Students and caregivers accept information regarding resources | 40. Provide students and caregivers lists of available referral |

if they continue to experience problems that interfere with daily functioning. (40, 41)

resources to be contacted if ongoing mental health concerns develop.

41. Provide students and caregivers with pamphlets and other literature regarding recovery from crises and traumatic events.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| V61.20 | Z62.820 | Parent-Child Relational Problem |
| V62.3 | Z55.9 | Academic or Educational Problem |
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 307.47 | F51.5 | Nightmare Disorder |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
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# SCHOOL TRAUMA (ELEMENTARY)

## BEHAVIORAL DEFINITIONS

1. The sudden death, serious injury, or maiming of a student, faculty member, or support staff (e.g., death due to congenital or chronic disease, choking, school bus tragedy, car accident, mugging, natural disaster, explosion, etc.).
2. Death of student, faculty member, or support staff due to a prolonged illness.
3. Death of a student, faculty member, or support staff due to suicide or homicide.
4. Pandemic that results in severe illness and/or death of students, faculty members, and/or staff.
5. Stalking or abduction of a student, faculty member, or support staff in the vicinity of the school.
6. An unknown person threatens violence to anyone in the vicinity of or within a school building.
7. Significant changes to the school facilities caused by fire, chemical infiltration through the heating/cooling system, or a natural disaster (e.g., tornado, earthquake, hurricane, flood).
8. Disclosure of the victimization or death of a student by parent, faculty member, or staff.
9. Bullying of students by other students, faculty members, or staff.
10. Disruption of typical sleep patterns following a traumatic event.
11. Preoccupation with or disclosure of suicidal or homicidal ideations.
12. Inability to regulate emotions following the traumatic event.
13. Tearfulness, restlessness, social withdrawal, clinginess, physical complaints, and reluctance/refusal to attend school.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore developmentally appropriate levels of behavioral and emotional functioning.
3. Reduction of physical complaints such as headaches and stomach discomfort.
4. Reinstate a sense of meaning for the future.
5. Return of a sense of safety to the students, faculty, and staff.
6. Re-establish healthy, age-appropriate relationships.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Staff ensures the physical safety of all students. (1, 2, 3) | 1. Direct the staff to move the students to a safe location. This location might vary depending on the situation.<br>2. Ask the staff to use attendance logs to identify and locate any missing students.<br>3. Direct the staff to get medical attention for injured students. |
| 2. Students reunite with caregivers and siblings as soon as possible. (4, 5, 6, 7, 8) | 4. Develop a list of the students' locations to facilitate communication with caregivers.<br>5. Contact caregivers as soon as possible following the event to |

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| | give them information about their student; this may involve activating an automatic communication system. |
| | 6. Directly contact the caregivers of children who have been injured to notify them of the trauma and give directions regarding where to meet their child. |
| | 7. Set up quiet, private or semi-private locations where the students, caregivers, and siblings can reunite. |
| | 8. Provide refreshments and communication (e.g., phones, computers) for the students and caregivers. |
| 3. Students cooperate with assessment of affective, behavioral, and cognitive reactions to the traumatic event. (9) | 9. Administer to the students assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Triage Assessment Scale for Students in Learning Environments (TASSLE), Traumatic Events Screening Inventory for Children–Brief Form [TESI-C-Brief] & Parent Report [TESI-PRR]) to guide treatment. |
| 4. Students and caregivers express their initial reaction to the trauma. (10) | 10. Reassure the students of their safety. Use active listening skills to encourage students and caregivers to talk about their thoughts and feelings. |
| 5. Students engage in calm, constructive play. (11, 12) | 11. Place limits on the students' behaviors that are potentially self-destructive (e.g., establish parameters of acceptable play activities). |
| | 12. Provide quiet rooms for the students to use to calm themselves. Monitor the student; |

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| | intervene as needed for the child's well-being. |
| 6. Students explore and express their feelings about and perception of the event. (13, 14, 15, 16) | 13. Use sand play or art therapy, allowing the students to explore and express their affective, behavioral, and cognitive reactions to the event. |
| | 14. Use play therapy (e.g., coloring books, dolls, puppets) to help the students express affective, behavioral, and cognitive reactions to the event. |
| | 15. Encourage and facilitate the students sharing affective, behavioral, and cognitive reactions with a professional therapist, family member, and/or trusted friend. |
| | 16. Help the students gain a realistic perspective of the event using developmentally appropriate language (e.g., reassure students that they are not to blame for event, injuries, or deaths, if these occurred). |
| 7. Students engage in behaviors that promote their safety in the community and at school. (17) | 17. Use role-play situations to promote safe behaviors by the students (e.g., stranger refusal, calling 911, pulling the fire alarm). |
| 8. Students engage in positive self-talk and problem solving to build confidence and overcome feelings of anxiety. (18, 19) | 18. Confront students' negative biases using cognitive restructuring that helps them develop more positive, realistic thoughts about the event and maintain confidence about their safety. |
| | 19. Help students activate healthy problem solving skills (e.g., pinpoint the problem, brainstorm possible solutions, list the pros and cons of each solution, select and implement a solution), assess and adjust solution if indicated. |

9. Family members identify positive consequences that may have resulted from the incident. (20)

10. Students verbalize an understanding of factual information regarding the traumatic event and its consequences. (21)

11. Staff and caregivers verbalize an understanding of common reactions to traumatic events. (22)

12. Caregivers discuss their concerns regarding their students' adjustment following their exposure to the traumatic event. (23, 24)

13. Students return to typical daily routines. (25, 26, 27)

20. Use reframing with family members to explore and identify positive changes (e.g., closer family relationships, increased appreciation of future, revised values) that occur following a crisis or traumatic event.

21. Disseminate factual information about the incident to the students as permitted using age-appropriate language.

22. Provide psycho-educational sessions for faculty, staff, and caregivers regarding typical reactions and poor recovery to crises or trauma.

23. Assist families to use healthy communication skills (e.g., owning feelings, not blaming, not minimizing feelings) to discuss the crisis or traumatic event.

24. Educate families on the importance of establishing typical daily routines to assist students in returning to normal functioning.

25. Provide structure for children based on individual need (e.g., post a visible schedule that children can check).

26. Educate the students about the importance of maintaining adequate eating and personal hygiene habits and help them plan ways to accomplish this.

27. Inquire about the students' sleeping patterns and suggest strategies to help him/her achieve restful, refreshing sleep (e.g., journaling, relaxation techniques).

14. Caregivers express their feelings about the tragic consequences of the traumatic incident. (28)

15. Students and family members verbalize an understanding of the death of acquaintances as a result of the traumatic incident. (29, 30, 31)

16. Students maintain focus on present rather than the past event. (32)

17. Staff revises safety procedures. (33, 34, 35)

28. Offer intervention group sessions to allow caregivers opportunities to express feeling and thoughts about the tragic consequences of the event.

29. If deaths occurred, discuss this with the students in age-appropriate language based on developmental levels of students. Avoid words that could confuse a child about the permanency of death (such as *sleeping, gone, moved on*) and respect cultural beliefs of students and caregivers.

30. Provide space for the students and family members to memorialize the deceased in accordance with school policy.

31. Assist in planning a memorial service in honor of the deceased, in which children, families, school personnel, and the community may take part.

32. Acknowledge the desire for answers, but redirect student(s) from focusing on *why* questions to identify the affect behind the questions.

33. Assist the staff in reviewing and revising safety plans; communicate changes to students and caregivers.

34. Educate staff on traumatic reactions children may display when a safety procedure drill is next enacted; provide literature and research to staff on managing children's reactions.

35. Assist the staff in revising policies and procedures around crisis management; communicate these to entire staff.

18. Caregivers receive information regarding mental health resources. (36, 37)

19. Staff monitors students for ongoing mental health concerns. (38, 39)

36. Provide pamphlets and other literature to the caregivers regarding recovery from crises and traumatic events.

37. Provide lists to caregivers of available referral resources for treating students if their behavioral or emotional reaction to the trauma exceeds what can be normally expected.

38. Utilize standard screening instrument to monitor students' mental health (e.g., Reynolds Child Depression Scale, Trauma Symptom Checklist for Children).

39. Conduct suicide and homicide assessments with the students as needed.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| V61.20 | Z62.820 | Parent-Child Relational Problem |
| V62.3 | Z55.9 | Academic or Educational Problem |
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| 307.46 | F51.4 | Non-Rapid Eye Movement Sleep Arousal Disorder, Sleep Terror Type |
| 307.46 | F51.3 | Non-Rapid Eye Movement Sleep Arousal Disorder, Sleepwalking Type |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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# SCHOOL TRAUMA (PRE-ELEMENTARY)

## BEHAVIORAL DEFINITIONS

1. The sudden death, serious injury, or maiming of a student, faculty member, or support staff (e.g., death due to SIDS, choking, school bus tragedy, car accident, mugging, natural disaster, explosion, etc.).
2. Death of student, faculty member, or support staff due to a prolonged illness.
3. Death of student, faculty member, or support staff due to suicide or homicide.
4. Stalking or abduction of a student, faculty member, or support staff in the vicinity of the school and/or child care facility.
5. An unknown person threatens violence to anyone in the vicinity of or within the school and/or child care building.
6. Significant changes to the school and/or child care facilities caused by fire, chemical infiltration through the heating/cooling system, or a natural disaster (e.g., tornado, earthquake, hurricane, flood).
7. Pandemic that results in severe illness and/or death of students, faculty members, and/or staff.
8. Disclosure of the victimization or death of a student by parent, faculty member, or staff.
9. Bullying of students by other students, faculty members, or staff.
10. Disruption of typical sleep patterns following a traumatic event.
11. Tearfulness, restlessness, social withdrawal, clinginess, physical complaints, and reluctance/refusal to attend school and/or child care.

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## LONG-TERM GOALS

1. Return to a pre-crisis level of functioning.
2. Restore developmentally appropriate levels of behavioral and emotional functioning.
3. Reduction of physical complaints such as headaches and stomach discomfort.
4. Reinstate a sense of meaning for the future.
5. Return of a sense of safety to the students, faculty, and staff.
6. Re-establish healthy age-appropriate relationships.

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## SHORT-TERM OBJECTIVES

1. Staff ensures the physical safety of all children. (1, 2, 3)

2. Staff unites children with caregivers and siblings as soon as possible. (4, 5, 6, 7)

## THERAPEUTIC INTERVENTIONS

1. Move children to a safe location; this location might vary depending on the situation.
2. Coordinate the staff efforts to identify and locate any missing children.
3. Arrange for the children to receive immediate medical attention if injured.
4. Contact the caregivers as soon as possible following the event to provide preliminary information about the traumatic incident; this may involve activating automatic communication system.
5. Develop a list of children's locations and communicate this information to the caregivers.
6. Directly contact caregivers of the children who have been injured

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| | to provide information about their care and location. |
| | 7. Set up quiet private or semi-private locations where children, caregivers, and siblings can reunite. |
| 3. Children and family members rest comfortably with each other. (8) | 8. Provide refreshments and communication equipment (e.g., phones, computers) for children and caregivers. |
| 4. Students cooperate with an assessment of their affective, behavioral, and cognitive reactions to the event. (9) | 9. Administer to the students assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Traumatic Events Screening Inventory for Children–Brief Form [TESI-C-Brief] & Parent Report [TESI-PRR]) to guide treatment. |
| 5. Children safely express affective reactions to the event. (10, 11, 12, 13) | 10. Use active listening skills to allow the students and caregivers to become aware of and express their feelings and thoughts. |
| | 11. Reassure the students of their safety and use basic listening skills to listen to children's and caregivers' questions. |
| | 12. Place limits on the students' behaviors that are potentially self-destructive (e.g., establish parameters of acceptable play activities). |
| | 13. Provide quiet rooms for the students to use to calm themselves. Monitor the student; intervene as necessary for the child's well-being. |
| 6. Children discuss the event in a safe and healthy manner. (14, 15) | 14. Use play therapy (e.g., coloring books, dolls, puppets) to help the children express affective, |

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| | behavioral, and cognitive reactions to the event. |
| | 15. Use art therapy or sand play to explore and allow the children's expression of affective, behavioral, and cognitive reactions to the event. |
| 7. Children engage in positive healthy actions as a result of the event. (16, 17) | 16. Help the children gain a realistic perspective of the event using developmentally appropriate language (e.g., reassure children that they are not to blame for event, injuries, or deaths if these occurred). |
| | 17. Assist the children in revising their dysfunctional thoughts about the event using cognitive behavioral techniques such as cognitive restructuring. |
| 8. Children and families learn and implement problem-solving skills. (18) | 18. Teach the children and caregivers to activate healthy problem-solving skills (e.g., pinpoint the problem, brainstorm possible solutions); discuss the pros and cons of each solution, select and implement a solution, assess satisfaction with the solution and modify it if necessary. |
| 9. Children demonstrate an understanding of safe behaviors. (19) | 19. Use role-play situations to promote safe behaviors by the children (e.g., stranger refusal, calling 911, pulling the fire alarm). |
| 10. Caregivers attend group sessions to express feelings with others affected by the traumatic incident. (20) | 20. Offer intervention group sessions to allow caregivers opportunities to express feeling and thoughts about the event. |
| 11. Children and caregivers verbalize an understanding of the death of acquaintances as a result of the traumatic incident. (21, 22, 23, 24) | 21. Disseminate factual information to the students as permitted using age-appropriate language. |
| | 22. If deaths occurred, discuss this in age-appropriate language based |

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| | on developmental levels of the children; respect cultural beliefs of children and caregivers. |
| | 23. Provide space for the children and family members to memorialize the deceased in accordance with school policy. |
| | 24. Assist in planning a memorial service in honor of the deceased in which children, families, school personnel, and the community may take part. |
| 12. Children return to typical day-to-day routines. (25, 26, 27, 28) | 25. Educate the families on the importance of establishing typical daily routines to assist with emotional recovery. |
| | 26. Educate the children about the important of maintaining adequate eating and personal hygiene habits and help them plan ways to accomplish this. |
| | 27. Provide structure for the children based on individuals' need (e.g., a visible schedule that children can check). |
| | 28. Inquire about the child's sleeping patterns and suggest strategies to help him/her achieve restful, refreshing sleep (e.g., relaxation techniques, sleep hygiene procedures). |
| 13. Children and family members identify positive consequences that may have resulted from the incident. (29) | 29. Use reframing to help the children and family members identify and explore positive changes (e.g., closer family relationships, increased appreciation of future) that occur following a crisis or traumatic event. |
| 14. Caregivers minimize distractions to assisting children to resolve their reactions to the event. (30) | 30. Offer intervention group sessions to allow the caregivers opportunities to express feelings and thoughts about the event. |

15. Staff and caregivers verbalize realistic expectations regarding children's reaction to that trauma. (31, 32, 33, 34)

31. Provide psychoeducational sessions for the faculty and staff regarding typical reactions to crises or trauma for children and caregivers.

32. Educate the parents, guardians, faculty, and staff members regarding signs of psychological problems associated with poor recovery from the event through ongoing group sessions

33. Provide pamphlets and other literature to the staff and caregivers regarding children's recovery from crises and traumatic events.

34. Provide lists to the parents and staff of available referral resources for treating students if their behavioral or emotional reaction to the trauma exceeds what can be normally expected.

16. Staff revises safety plans and procedures. (35, 36, 37)

35. Assist the staff in reviewing and revising safety plans; communicate changes to children and caregivers.

36. Revise policies and procedures involving crisis management as needed and communicate changes to the students, staff, and parents.

37. Assist the staff in revising policies and procedures around crisis management; communicate these to entire staff.

17. Children submit to ongoing mental health assessment. (38)

38. Utilize standard screening instrument to monitor students' mental health (e.g., Reynolds Child Depression Scale, Trauma Symptom Checklist for Children).

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| V61.20 | Z62.820 | Parent-Child Relational Problem |
| V62.3 | Z55.9 | Academic or Educational Problem |
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| 307.46 | F51.4 | Non-Rapid Eye Movement Sleep Arousal Disorder, Sleep Terror Type |
| 307.46 | F51.3 | Non-Rapid Eye Movement Sleep Arousal Disorder, Sleepwalking Type |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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# SCHOOL TRAUMA (SECONDARY)

## BEHAVIORAL DEFINITIONS

1. The sudden death, serious injury, or maiming of a student, faculty member, or support staff (e.g., motor vehicle accident, school bus tragedy, homicide, natural disaster, explosion, etc.).
2. Death of student, faculty member, or support staff due to a prolonged illness.
3. Death of a student, faculty member, or support staff due to suicide or homicide.
4. Death of student while participating in a school-supported activity such as athletic or social event.
5. Pandemic that results in severe illness and/or death of students, faculty members, and/or staff.
6. Stalking or abduction of a student, faculty member, or support staff in the vicinity of the school.
7. Gang intrusion or involvement resulting in violence in the school or school-supported activity.
8. An unknown person threatens violence to anyone in the vicinity of or within a school(s) building(s).
9. Significant changes to the school facilities caused by fire, chemical infiltration through the heating/cooling system, or a natural disaster (e.g., tornado, earthquake, hurricane, flood).
10. Disclosure of the victimization or death of a student by parent, faculty member, or staff.
11. Bullying of students by other students, faculty members, or staff.
12. Disruption of typical sleep patterns following a traumatic event.
13. Inability to regulate emotions following the traumatic event.
14. Preoccupation with or disclosure of suicidal or homicidal ideations.
15. Feelings of irrational guilt regarding having been a survivor of the trauma while others suffered or died.
16. Persistent fear of death or personal injury.

17. Grief expressed in sadness, tearfulness, and /or isolating self from peers/ family.
18. Persistent reluctance to leave the home to attend school and becoming socially withdrawn.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore developmental appropriate levels of behavioral and emotional functioning.
3. Reduce physical complaints such as headaches and stomach discomfort.
4. Re-establish a sense of meaning for the future.
5. Return of a sense of safety to the students, faculty, and staff.
6. Re-establish healthy age-appropriate relationships.

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## SHORT-TERM OBJECTIVES

1. Staff ensures the physical safety of all students. (1, 2, 3)

## THERAPEUTIC INTERVENTIONS

1. Direct the staff to move the students to a safe location. This location might vary depending on the situation.
2. Ask the staff to use attendance logs to identify and locate any missing students.

3. Direct the staff to get medical attention to injured students.

2. Students reunite with caregivers and siblings as soon as possible. (4, 5, 6, 7, 8)

4. Develop a list of students' locations to facilitate communication with caregivers.

5. Contact the caregivers as soon as possible following the event to give them information about their student; this may involve activating an automatic communication system.

6. Directly contact the caregivers of students who have been injured to notify them of the trauma and give directions regarding where to meet their student.

7. Set up quiet, private or semi-private locations where the students, caregivers, and siblings can reunite.

8. Provide refreshments and communication (e.g., phones, computers) for the students and caregivers.

3. Students cooperate with an assessment of their affective, behavioral, and cognitive reactions to the event. (9)

9. Administer to the students assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form; Crisis Intervention–Revised, Triage Assssment Scale for Students in Learning Environments [TASSLE], Traumatic Events Screening Inventory for Children–Brief Form [TESI-C-Brief], and Parent Report [TESI-PRR], Trauma Symptom Checklist for Children, Symptom Checklist–90–Revised) to guide treatment.

4. Students and caregivers express their initial reaction to the trauma. (10, 11)

10. Reassure the students of their safety and use active listening skills to encourage students and

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| | caregivers to talk about their thoughts and feelings. |
| | 11. Provide quiet rooms for the students to use to calm themselves with monitoring and support from staff and/or caregivers. |
| 5. Students explore and express their feelings about and perception of the event. (12, 13, 14, 15) | 12. Use art therapy to explore and allow the students' expression of affective, behavioral, and cognitive reactions to the event. |
| | 13. Use active listening skills to validate and explore the students' affective, behavioral, and cognitive reactions while he/she recounts the trauma in as much detail as they are comfortable with (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| | 14. Facilitate a controlled expression of feelings by placing limits on the students to articulate those feelings in a safe, non-threatening, non-self-destructive manner. |
| | 15. Support and facilitate the students sharing affective, behavioral, and cognitive reactions with a professional therapist, family member, and/or trusted friend. |
| 6. Students express a realistic perspective on the traumatic incident. (16) | 16. Help the students gain a realistic perspective of the event using appropriate language (e.g., reassure students that they are not to blame for event, injuries, or deaths if these occurred). |
| 7. Students implement peaceful conflict resolution skills. (17) | 17. Use role-play situations to promote the students' learning |

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| | how to resolve differences with others peacefully (e.g., conflict resolution, mediation skills). |
| 8. Students engage in positive self-talk and problem solving to build confidence and overcome feelings of anxiety resulting from the event. (18, 19) | 18. Confront students' negative biases using cognitive restructuring in order to develop more positive, realistic thoughts about the event and maintain confidence about their safety. |
| | 19. Help the students activate healthy problem solving skills (e.g., pinpoint the problem, brainstorm possible solutions, list the pros and cons of each solution, select and implement a solution, assess and adjust solution if indicated). |
| 9. Students learn and implement calming and coping strategies to manage the anxious reactions to the incident. (20) | 20. Teach the students strategies from stress inoculation training such as relaxation, breathing control, covert modeling (e.g., imagining the successful use of the strategy) for managing fears until a sense of mastery is evident. |
| 10. Students participate in imaginal and *in vivo* exposure to trauma-related memories until thinking about the trauma does not result in marked distress. (21) | 21. Have the student undergo imaginal exposure to events about the trauma by having him/her describe the experience at an increasing but client-chosen level of detail; repeat until associated anxiety reduces and stabilizes; review and reinforce progress while using problem solving skills to reduce obstacles. |
| 11. Students decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the event. (22) | 22. Assess the students for increased use of alcohol and other mood-altering substances following the event, which are used as a means of coping with the trauma; continue to monitor and discourage this maladaptive |

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| | coping behavior, referring for addiction treatment if necessary. |
| 12. Students verbalize an understanding of factual information regarding the traumatic event and its consequences. (23) | 23. Disseminate factual information about the incident to the students as permitted using age-appropriate language. |
| 13. Students and family members verbalize an understanding of the death of acquaintances as a result of the traumatic incident. (24, 25, 26) | 24. If deaths occurred, discuss this with the students in age-appropriate language based on developmental levels of students. Respect cultural beliefs of students and caregivers. |
| | 25. Provide space for the students and family members to memorialize the deceased in accordance with school policy. |
| | 26. Assist in planning a memorial service in honor of the deceased in which children, families, school personnel, and the community may take part. |
| 14. Students implement previously effective stress management strategies to reduce current affective distress. (27) | 27. Explore the students' history of experiencing other traumatic events and determine healthy and effective coping mechanisms used at that time; encourage the use of those strategies with the current incident. |
| 15. Family members identify positive consequences that may have resulted from the incident. (28) | 28. Use reframing with family members to explore and identify positive changes (e.g., closer family relationships, increased appreciation of future, revised values) that occur following a crisis or traumatic event. |
| 16. Students engage in positive, healthy, constructive social interaction to prevent isolation and withdrawal and build self-esteem. (29, 30) | 29. Direct the student to organizations or programs that focus on prevention (e.g., suicide prevention hotlines, anti-bullying program, SADD—Students Against Drunk Driving drug prevention programs). |

30. Schedule structured activities (e.g., assemblies, structured, in-class social activities) that facilitate student's interacting with others.

17. Students return to typical daily routines. (31, 32, 33)

31. Provide structure for the student based on individual need (e.g., a visible schedule that students can check).

32. Educate students about the importance of maintaining adequate eating and personal hygiene habits and help him/her plan ways to accomplish this.

33. Inquire about students' sleeping patterns and suggest strategies to help them achieve restful, refreshing sleep (e.g., journaling, relaxation techniques).

18. Students maintain focus on the present rather than on the event. (34)

34. Acknowledge the desire for answers, but redirect the students from focusing on *why* questions to identify the affect behind the questions.

19. Caregivers discuss their concerns regarding their students' adjustment following their exposure to the traumatic event. (35, 36, 37)

35. Offer intervention group sessions to allow the caregivers opportunities to express feeling and thoughts about the event.

36. Assist families to use healthy communication skills (e.g., owning feelings, not blaming, not minimizing feelings) to discuss the crisis or traumatic event.

37. Educate families on the importance of establishing typical daily routines to assist students in returning to normal functioning.

20. Staff revises safety plan and procedures. (38, 39, 40)

38. Assist the school administration in reviewing the implementation of crisis plan (e.g., communicating

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| | with caregivers, moving students to safety, writing notification memos, talking with media, involvement of outside agencies, relationship with law enforcement) in order to revise this. |
| | 39. Review and revise safety plans and communicate changes to the students and caregivers. |
| | 40. Educate staff on traumatic reactions children may display when a safety procedure drill is next enacted; provide literature and research to staff on managing children's reactions. |
| 21. Staff and caregivers verbalize an understanding of common reactions to traumatic events. (41) | 41. Provide psychoeducational sessions for the faculty, staff, and caregivers regarding typical reactions and poor recovery to crises and trauma. |
| 22. Caregivers receive information regarding mental health resources. (42, 43) | 42. Provide to the caregivers pamphlets and other literature regarding recovery from crises and traumatic events. |
| | 43. Provide lists to caregivers of available referral resources for treating students if their behavioral or emotional reaction to the trauma exceeds what can be normally expected. |
| 23. Staff monitors students for ongoing mental health concerns. (44, 45) | 44. Utilize standard screening instrument to monitor students' mental health (e.g., Beck Depression Inventory II, General Anxiety Disorder–7 [GAD-7], Trauma Symptom Checklist). |
| | 45. Conduct suicide and homicide assessments with the students as needed. |

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| V61.20 | Z62.820 | Parent-Child Relational Problem |
| V62.3 | Z55.9 | Academic or Educational Problem |
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| 307.46 | F51.4 | Non-Rapid Eye Movement Sleep Arousal Disorder, Sleep Terror Type |
| 307.46 | F51.3 | Non-Rapid Eye Movement Sleep Arousal Disorder, Sleepwalking Type |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 307.47 | F51.5 | Nightmare Disorder |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
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# SCHOOL TRAUMA (STAFF)

## BEHAVIORAL DEFINITIONS

1. The traumatic, sudden death, or serious injury of student's teacher, professor, faculty members, or support staff (e.g., due to suicide, motor vehicle accident, residence hall accident or fire, natural disaster, explosion, etc.).
2. Death of a student, faculty member, support staff, or other school personnel after a prolonged illness.
3. Invasion of school or college campus by one or more persons carrying lethal weapons that threaten and/or injure/murder students, faculty members, or other school personnel.
4. Sudden death of student while participating in a school-supported activity such as an athletic or social event.
5. Stalking, kidnapping, or sexual assault on or near the school or college campus of student, faculty member, or support staff.
6. Pandemic that results in severe illness and/or death of students, faculty members, and/or staff.
7. Dramatic structural damage to a school or college building(s) physical plant caused by fire, explosion, bomb threat, chemical spill, or natural disaster (e.g., tornado, hurricane, flood, earthquake).
8. An unknown person(s) threatens violence to anyone in the vicinity of or within the school or campus building(s).
9. Experience of flashbacks, replaying the event over and over in the mind, sense of unreality or disbelief, impaired memory, short attention span, angry thoughts, avoidance of certain locations/building on a school or college campus, and/or significant increased fear of the same thing happening again.
10. Increased use of alcohol or other mood-altering substances following a traumatic event.
11. Persistent fear of death or personal injury occurring to self following the event.

12. Decrease in morale resulting in withdrawal from normal routine work responsibilities and activities.
13. Decrease in confidence regarding decision-making skills.
14. Inability to regulate emotions following the event.
15. Feelings of guilt regarding having been a survivor of a crisis or trauma in which others died.
16. Diminished job performance following the event.
17. Preoccupation or disclosure of suicidal or homicidal ideations by students, faculty member, support staff, or school personnel.
18. Increase of conflicts with other school personnel following the events.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore appropriate levels of emotional, behavioral, and cognitive functioning.
3. Assimilate the traumatic event into daily life experiences without ongoing distress.
4. Re-establish a sense of meaning for the future.
5. Return of a sense of safety to the school personnel and their families.
6. Re-establish appropriate work-related relationships.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Cooperate with completing objective assessment instruments. (1) | 1. To guide intervention that is needed, assess the staff member's affective, behavioral, and cognitive reactions to the incident through the use of instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Symptom Checklist–90–Revised, Trauma Symptom Checklist). |
| 2. Identify any physical injury or symptoms that resulted from the incident. (2) | 2. Inquire as to the medical care that has been received or refer the staff member to a physician as appropriate. |
| 3. Verbalize how the incident has affected thoughts, feelings, and behavior. (3, 4, 5) | 3. Reassure the staff member of his/her safety and use active listening skills to explore the affective, behavioral, and cognitive reactions while he/she recounts the trauma in as much detail as is comfortable to share (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| | 4. Encourage and facilitate the staff member sharing affective and cognitive reaction with a professional peer, family member, and/or trusted friend. |
| | 5. Assess and explore for possible transference of unresolved feelings from a previous event onto this incident. |
| 4. Report confidence in the actions taken during the incident rather than second-guessing these. (6, 7) | 6. Ask the staff member to share his/her thought process before and during the incident that led to his/her actions; reassure |

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| | him/her of the automatic response that comes in crisis situations. |
| | 7. Confront the staff member when he/she negatively evaluates his/her performance during the incident and redirect him/her toward a realistic, non-judgmental perspective by focusing on the facts of what took place and his/her reasonable response. |
| 5. Decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the event. (8) | 8. Assess the staff for increased use of alcohol and other mood-altering substances that are used as a means of coping with the trauma; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary. |
| 6. Learn and implement calming and coping strategies to manage the reactions to the incident. (9) | 9. Coach the staff to use strategies from stress inoculation training such as relaxation, breathing control, covert modeling (i.e., imagining the successful use of the strategy) to manage fears. |
| 7. Staff engages in positive self-talk and problem solving to build confidence and overcome feelings of anxiety. (10, 11) | 10. Explore the staff member's schema and self-talk that mediates incident-related fears; challenge negative biases and assist him/her in generating appraisals that correct for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| | 11. Assign the staff member a homework exercise (e.g., listing five negative statements and five disputing statements), in which he/she identifies fearful self-talk and creates reality-based |

alternatives; review and reinforce success, providing corrective feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

8. Discuss feelings and perceptions of the event with peers. (12, 13)

12. Refer the staff to a group session for trauma victims to talk among themselves their experiences regarding the traumatic incident; this may be a structured group (e.g., psychological debriefing group) or a process group.

13. Refer the staff to an unstructured self-help group focusing on recovery from a traumatic incident.

9. Verbalize an understanding of mental health assistance to be given to students reacting to the trauma. (14, 15)

14. Assure school personnel that professional assistance will be available for students who become distraught when a normal routine is resumed at the school.

15. Assure school personnel that ongoing screening for students will take place during the recovery process.

10. Interact with friends, family, and peers to prevent isolation and withdrawal. (16, 17)

16. Encourage the staff to make arrangements for social opportunities (e.g., luncheons, outings with friends) as appropriate to interact with other staff.

17. Assist the staff in identifying trusted family members, friends, and/or other social systems that can be used for support during recovery.

11. Implement previously effective stress management strategies that can be implemented to reduce current affective distress. (18)

18. Explore the staff's history of experiencing other traumatic events and determine healthy and effective coping mechanisms used at that time; encourage the

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| | use of those strategies with the current incident. |
| 12. Identify positive consequences that may have resulted from the traumatic event. (19) | 19. Use reframing with the staff to explore and identify positive changes (e.g., closer family relationships, increased appreciation of future) associated with positive recovery and resiliency following an incident. |
| 13. Implement calming skills to reduce anxiety and manage anxiety symptoms. (20, 21) | 20. Teach school personnel relaxation skills (e.g., progressive muscle relaxation, guided imagery, slow diaphragmatic breathing) and how to apply these in daily life. |
| | 21. Use biofeedback techniques to facilitate the staff's success at learning relaxation skills. |
| 14. Verbalize an understanding of common reactions to traumatic events. (22) | 22. Educate school staff regarding signs of psychological problems associated with poor recovery from the event. |
| 15. Family members of staff use healthy communication skills when discussing the traumatic event. (23) | 23. Meet with family members to teach them healthy communication skills (e.g., reflective listening, eye contact, respect, etc.) to be used when discussing the crisis or traumatic event. |
| 16. Re-establish family daily routines to facilitate recovery process. (24) | 24. Inform families on the importance of establishing typical daily routines to assist in recovery. |
| 17. Engage in positive healthy, constructive actions to prevent future incidents. (25, 26) | 25. Train school personnel to use conflict resolution and mediation skills with students who feel alienated. |
| | 26. Assist the staff in developing programs to prevent violence and other traumatic incidents. |

18. Attend and participate in a memorial service to the deceased. (27, 28, 29)

19. Commemorate the memory of the victims of the traumatic event on significant dates. (30, 31, 32)

20. Review and revise crisis and safety plans. (33, 34)

27. Encourage the staff to attend the funeral of the student(s) or deceased coworker(s) to facilitate the grieving process. Explore their reactions afterwards.

28. Ask the staff to write about their memories of the deceased to be collected in a book for the deceased's spouse/caregivers.

29. Encourage the staff to memorialize the deceased with their own remembrance (e.g., poems, drawing, flowers, photos, monetary contributions to a cause the deceased supported); designate a place for collection.

30. Prompt the staff to talk about the impact of the loss and alteration of their lives resulting from the incident on the approaching anniversary day of the incident or on other trigger dates (holidays, graduation).

31. Encourage the design of an activity to be implemented around major life events (e.g., holidays, graduation, one-year anniversary) to remember the victims and honor the survivors.

32. Teach the staff about the possible increase of affective disturbances that is associated with the anniversary date or other trigger events; develop coping techniques or rituals to decrease anniversary reactions.

33. Assist school personnel in reviewing the implementation of a crisis plan (e.g., communicating with caregivers, moving students to safety, writing notification memos, talking with media, involvement

of outside agencies, relationship with law enforcement) in order to revise this.

34. Assist the staff in reviewing and revising safety plans; communicate changes to all school personnel.

21. Monitor own recovery process and seek counseling if maladaptive reactions to the trauma appear. (35, 36, 37)

35. Educate the staff regarding signs of psychological problems associated with poor recovery from the traumatic incident; develop a plan to seek counseling if maladaptive reactions persist (e.g., sleep disturbance, irritability, hypervigilance, depression, survivor guilt, etc.).

36. Provide the staff with pamphlets and other literature regarding recovery from crises and traumatic events.

37. Provide the staff with a list of available crisis counseling referral resources.

22. Cooperate with an assessment to determine the presence or absence of an ongoing dysfunctional reaction to the trauma. (38, 39)

38. Administer to the staff assessment instruments specifically designed for crisis and traumatic situations (e.g., Traumatic Life Events Questionnaire, Trauma Symptom Inventory–2, General Anxiety Disorder–7 [GAD-7], Beck Depression Inventory–II) to identify at risk survivors and guide treatment.

39. Conduct suicide and homicide assessments with the staff as needed.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| V62.2 | Z56.9 | Other Problem Related to Employment |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 307.47 | F51.5 | Nightmare Disorder |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
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# SEXUAL ASSAULT

## BEHAVIORAL DEFINITIONS

1. Self-report of being forced into sexual activity with another person.
2. Injuries (e.g., abrasions, bruises, cuts, venereal disease, etc.) that give evidence of the sexual assault.
3. Recurrent intrusive memories, nightmares, and/or thoughts of the assault.
4. Avoidance of situations related to the assault.
5. Anxiety, subjective sense of numbing, helplessness, fear, irritability, afraid to be in public places or crowds alone since the assault.
6. Feelings of vulnerability, powerlessness, guilt, or shame.
7. Insomnia, difficulty concentrating, motor restlessness, depression, restricted range of affect.
8. Abstaining from intimacy, pain during intercourse, avoidance of sexual encounters since the assault.

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## LONG-TERM GOALS

1. Return to the level of psychological, emotional, social, and occupational functioning present before the assault.
2. Diminish intrusive images and the alteration in functioning or activity level that is due to stimuli associated with the assault.
3. Assimilate the assault event into daily life experiences without ongoing distress.
4. Return to the level of sexual intercourse satisfaction prior to the assault.

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## SHORT-TERM OBJECTIVES

1. Describe the assault, providing as much detail as comfort allows. (1, 2, 3, 4)

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client in individual sessions through consistent eye contact, asking open-ended questions, offering unconditional positive regard, and showing warm acceptance to explore the client's emotional reaction at the time of the assault.
2. Obtain a release of information from the client to appropriate agencies/individuals (law enforcement agencies, health care professionals, work/school personnel, relatives) and consult with those who have factual details of the assault.
3. Coordinate a sexual assault assessment (description of the assault; when/where the assault occurred; the impact of the assault upon personal, social, family, and vocational activities) to occur in collaboration with law enforcement professionals to prevent further traumatization from the client restating the details of the assault multiple times.
4. Encourage the client to work collaboratively with law enforcement; confront any resistance such as fear of

retaliation, feelings of hopelessness or helplessness, and so on, by reminding the client of the need to establish and maintain her/his safety.

2. Cooperate with a medical assessment and evidence collection related to the assault. (5, 6)

5. Refer the client to a physician trained in sexual abuse examinations for evidence collection and evaluation of any injuries; monitor the client's compliance with the assessment and treatment recommendations.
6. Assist in getting the client to her/his physician, urgent care, or emergency department for a medical evaluation.

3. Describe emotional reactions experienced since the assault and how daily functioning has been impacted. (7, 8, 9)

7. Create with the client a symptom development time line to identify how the assault has negatively impacted her/his life.
8. Discuss how the client's activities of daily living have changed to avoid confrontation, vulnerability, or shame since the assault occurred.
9. Assess the client's frequency, intensity, and duration of traumatic reactions on her/his emotional, cognitive, and behavioral impact on functioning using an objective instrument (e.g., Trauma Symptom Inventory–2).

4. Verbalize symptoms of anxiety or depression, including any suicidal ideation. (10, 11)

10. Administer to the client a self-report measure (e.g., Beck Depression Inventory–II by Beck or General Anxiety Disorder–7 [GAD-7]) to assess the depth of depression and/or anxiety symptoms and suicide risk; evaluate the results and give feedback to the client.
11. Assess and monitor the client's suicide potential; arrange for

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| | psychiatric hospitalization, as necessary, when the client is determined to be harmful to self. |
| 5. Verbally identify flashbacks. Learn and implement thought-stopping to manage intrusive unwanted thoughts. (12, 13) | 12. Explore whether the client has had any flashback experiences related to the assault; assign the client a homework exercise of writing recurring images or memories associated with the assault; process in session. |
| | 13. Teach the client to implement a thought-stopping technique (thinking of a stop sign and then a pleasant scene) immediately upon experiencing unwanted thoughts; monitor and encourage the client's use of the technique in daily life between sessions (or assign the "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| 6. Utilize behavioral strategies to reduce cognitive, emotional, and/or behavioral stress reactions. (14, 15, 16) | 14. Explore the reduction of distress by the client participating in activities that involve physical engagement; reinforce the client's engagement in the activities and assist the client in adopting the activities into his/her daily life. |
| | 15. Assist the client in developing behavioral coping strategies (e.g., less internal focus, increased social involvement, maintaining a journal, improved sleep, eating a balanced diet, avoiding use of alcohol or drugs, reducing caffeine or nicotine intake, getting a massage, establishing an exercise routine) for reducing feelings of depression and anxiety; reinforce success in session. |

16. Develop a *coping card*, on which coping strategies and other important information are written for the client's later use (e.g., "You're safe," "Pace your breathing," "Focus on the task at hand," "You can manage it," "Let the anxiety pass," and "Call support person").

7. Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk. (17, 18, 19)

17. Assign the client a homework exercise in which she/he journals times when emotional distress is successfully managed between sessions and when she/he identifies fearful self-talk and creates reality-based alternatives (see "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma); review and reinforce success, providing corrective feedback for failure.

18. Teach the client how to use an automatic thought record to identify and track distorted cognitions about the rape; challenge and replace the negative self-talk with positive, empowering self-talk.

19. Teach the client a guided self-dialogue procedure in which she/he learns to recognize maladaptive self-talk, challenge its biases, cope with engendered feelings, overcome avoidance, and reinforce her/his accomplishments; review and reinforce progress; problem-solve obstacles.

8. Learn and implement assertiveness techniques to increase self-confidence. (20, 21)

20. Teach the client assertiveness techniques (eye contact, posture, personal space, active listening, etc.) to be used with confidence when feeling insecure or

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| | vulnerable. Reflect on feelings of confidence versus helplessness when using assertiveness. |
| | 21. Refer the client to self-defense classes, Tae Bo, or karate classes to increase a sense of mastery and self-confidence and decrease feelings of vulnerability. |
| 9. Identify, challenge, and replace self-blame with an understanding that the assault is the responsibility of the perpetrator. (22, 23, 24) | 22. When the client expresses guilt/self-blame, redirect the client to view the assault as a crime committed against her/him for which the perpetrator is to blame. |
| | 23. Confront and challenge any of the client's minimizing or making excuses regarding the seriousness of the assault; assess if the client believes she/he is to blame for the assault. |
| | 24. Assign the client a homework exercise in which she/he identifies themselves in self-talk to be at blame for the assault and create reality-based alternatives. Review and reinforce success in sessions, providing corrective feedback for failure. |
| 10. Learn and implement relaxation techniques to reduce and manage anxiety symptoms. (25, 26, 27) | 25. Teach the client relaxation skills (e.g., self-guided imagery, progressive muscle relaxation, deep rhythmic breathing, meditation, positive self-talk) to address anxiety symptoms that may emerge during encounters with situations, sounds, settings related to the assault; assign daily practice of the relaxation skill. |
| | 26. Utilize biofeedback techniques to facilitate the client learning relaxation skills; monitor compliance and effectiveness while providing corrective feedback toward improvement. |

27. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with the assault; develop a plan for exposure to these situations to reduce the symptoms.

11. Return to the scene of the event. (28, 29)

28. Develop a plan for managing the emotional reactions generated by graduated exposure to the location of the assault. Go to the location of the assault with the client, offering support and encouragement to utilize the techniques identified in session to manage reactions.

29. Use exposure therapy methods in conjunction with learned relaxation techniques to help the client reduce stress reactions as they develop at the location of the assault.

12. Provide honest and complete information for a chemical dependence biopsychosocial history. (30, 31, 32)

30. Assess the client for the presence of chemical dependence; educate her/him on the importance of abstaining from chemical use in treatment recovery; monitor compliance.

31. Use a biospychosocial history to help the client understand the familial, emotional, and social factors that contributed to the development of chemical dependence.

32. Refer the client for treatment for chemical dependence and/or 12-step group to establish and maintain sobriety.

13. Learn and implement problem-solving strategies to reduce the negative impact the assault has had on intimacy or sexual relations. (33, 34, 35)

33. Encourage the client to openly communicate with her/his sex partner her/his difficulties with intimacy/sexual relations; use modeling, role-playing, and

behavior rehearsal to work through conflicts.

34. Assign the client to keep a journal of thoughts and emotions when sexually aroused with a consensual partner; review and reinforce progress, problem solving obstacles.
35. Teach problem-solving strategies specifically defining a problem, generating options for addressing it, evaluating the pros and cons of the options, selecting and implementing an option, and reevaluating and refining the action taken.

14. Identify individuals that will offer physical and emotional support in times of distress. (36, 37, 38)

36. Offer a family or group therapy session to have the client communicate to family or friends her/his experience with being a victim of sexual assault; educate family/friends on ways they can help support the client (e.g., using active listening, modulating emotional reactions, giving positive encouragement).
37. Engage the client in drawing an eco-map to identify people whom the client can rely upon for support; review eco-map, encouraging the client to have frequent communication with supportive people to reduce feelings of insecurity, powerlessness, or anxiety.
38. Discuss with the client people to solicit for support at work (e.g., supervisor, employee assistance program personnel, security officers); review progress in session addressing resistance or noncompliance.

15. Participate in a victim of sexual assault support group. (39)

39. Refer the client to a support group that is focused on victims

of sexual assault; encourage the client to share her/his assault experience and its effects with other survivors in the group.

16. Maintain involvement in social and vocational activities, assimilating the traumatic event into daily living. (40)

40. Encourage the client to return to work, social engagements, and/or daily routines that occurred prior to the assault; phase these activities into daily living gradually, but steadily, if necessary.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 308.3 | F43.0 | Acute Stress Disorder |
| 309.24 | F43.22 | Adjustment Disorder, With Anxiety |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.28 | F43.23 | Adjustment Disorder, With Mixed Anxiety and Depressed Mood |
| 300.6 | F48.1 | Depersonalization/Derealization Disorder |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 296.2x | F32.x | Major Depressive Disorder, Single Episode |
| 296.3x | F33.x | Major Depressive Disorder, Recurrent Episode |
| V61.10 | Z63.0 | Relationship Distress With Spouse or Intimate Partner |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| V61.12 | Z69.12 | Encounter for Mental Health Services for Perpetrator of Spouse or Partner Violence, Physical |
| 995.81 | Z69.11 | Encounter for Mental Health Services for Victim of Spouse or Partner Violence, Physical |
| 301.82 | F60.6 | Avoidant Personality Disorder |
| 301.6 | F60.7 | Dependent Personality Disorder |
| 301.50 | F60.4 | Histrionic Personality Disorder |
| 301.0 | F60.0 | Paranoid Personality Disorder |
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# STALKING VICTIM

## BEHAVIORAL DEFINITIONS

1. Subjected to repeated or continued harassment in the form of a contact that is initiated or continued without consent, or in disregard of own expressed desire that the contact be avoided or discontinued.
2. Received one or more credible threats against self, a member of the family, or another individual living in the household.
3. Movements inside and/or outside of the home have been monitored, unexplained phone calls, insignificant personal or home property tampered with for no apparent reason.
4. An unwanted person has been spying on actions, conversations, or paths of travel.
5. Verbalizes feelings of terror, persecution, intimidation, paranoia, or entrapment.
6. Has made changes in daily routines (e.g., route taken to work/school) to determine if stalking is occurring.
7. Experiences difficulty falling asleep, loss of appetite, homicidal/suicidal ideation, decreased sense of trust.

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## LONG-TERM GOALS

1. Take legal steps necessary to guarantee safety.
2. Develop the skills necessary to maintain physical and emotional safety in current and future relationships.

3. Return to the level of psychological, emotional, social, and occupational functioning present before the stalking began.

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## SHORT-TERM OBJECTIVES

1. Describe the history, nature, and intensity of the stalking. (1, 2, 3)

2. Describe emotional reactions experienced since the stalking started and how daily functioning has been impacted. (4, 5, 6)

## THERAPEUTIC INTERVENTIONS

1. Actively develop rapport with the client by providing unconditional positive regard, asking open-ended questions, and maintaining a supportive, nonjudgmental attitude.

2. Review with the client relationships that have ended and the circumstances surrounding these relationships to assist him/her in identifying possible stalking suspects; identify the individual(s) who may be stalking.

3. Gather from the client a history of the stalking, determining when the stalking began, situations that occurred prior to the start of the stalking, and the impact of the stalking upon personal, social, and professional activities.

4. Administer to the client a self-report measure (e.g., Beck Depression Inventory –II or General Anxiety Disorder–7 [GAD-7]) to assess the depth of depression and/or anxiety symptoms.

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| | 5. Identify what actions the client has already taken to address the stalking (rerouting of activities, attempts to talk with the stalker, items of protection being implemented, etc.). |
| | 6. Assess for implied or stated harm to the client's home, family members, friends, or support systems; determine realistic level of harm to others, taking the necessary advisory precautions as indicated. |
| 3. Identify and replace cognitive messages that promote fear, worry, or anxiety and its treatment. (7, 8, 9) | 7. Teach the client how to use an automatic thought record to identify and track distorted cognitions about the stalking; challenge the thoughts and assist him/her in replacing the cognitive distortions related to the stalking with more realistic messages. |
| | 8. Help the client develop reality-based cognitive messages that will increase self-confidence and facilitate a reduction in fear, worry, or anxiety responses. |
| | 9. Reinforce the client's positive, reality-based cognitive messages that enhance self-confidence and increase adaptive actions (see "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| 4. Develop a safety plan for protection from ongoing stalking; cooperate with authorities in their investigation. (10, 11, 12, 13) | 10. Assist the client in developing a written safety plan that details what actions (e.g., filing a police report, obtaining an order of protection or personal restraining order, using alternate routes for transportation, contacting support persons, etc.) will be taken to establish and |

maintain physical and emotional safety.

11. Suggest the client work collaboratively with law enforcement; confront any resistance such as fear of retaliation, feelings of hopelessness or helplessness, and so on, by reminding the client of the need to establish and maintain her/his safety.
12. Assist the client in identifying ways to increase safety in the home (e.g., installing dead-bolt locks, keeping curtains drawn, purchasing a cordless/wireless phone, identifying an escape route, installing a security system, and/or shredding personal information on letters or paperwork) for a greater sense of security; review and reinforce progress.
13. Discuss with the client's friends or family who would be willing and able to provide a safe, protected living situation; encourage the client to move in with those individuals until safety is established; monitor compliance and progress.

5. Change daily routines to decrease likelihood of the stalker knowing the client's whereabouts. (14, 15)

14. Assign the client to complete a time study of his/her daily actions and activities for a week; review in session, assessing for options in alterations to his/her routine schedules (e.g., leaving/arriving home at different times, attending activities at a different time, have visitors to the house and stay overnight so as to not consistently be home alone).
15. Assist the client in identifying alternative routes to school,

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| | work, and other activities; encourage her/him to use these alternative routes to increase safety; monitor the client's compliance in using the alternative routes. |
| 6. Learn and implement assertiveness techniques to increase self-confidence. (16, 17, 18) | 16. Teach the client assertiveness techniques (eye contact, posture, personal space, active listening, broken record, etc.) to be used with confidence when feeling threatened; reflect on feelings of confidence versus helplessness when using assertiveness. |
| | 17. Role-play with the client a one-time, clear communication scenario with the stalker where contact or a relationship now or in the future is not wanted is expressed; demonstrate use of language that is not threatening and does not allow arguing or negotiating with the stalker to occur; reinforce the dialogue to occur in a public place with a support person present. |
| | 18. Refer the client to self-defense classes, Tae Bo, or karate classes to increase a sense of mastery and self-confidence and decrease feelings of vulnerability. |
| 7. Utilize behavioral strategies to overcome anxiety and/or depression. (19, 20, 21) | 19. Develop and reinforce a routine of physical exercise (e.g., brisk walk, step aerobics, bike riding) designed to elevate the client's mood; reinforce success. |
| | 20. Explore the reduction of distress by the client participating in activities that involve physical engagement; reinforce the client's engagement in the activities and assist the client in adopting the activities into his/her daily life. |

21. Assist the client in developing behavioral coping strategies (e.g., less internal focus, increased social involvement, maintaining a journal, improving sleep, eating a balanced diet, avoiding use of alcohol or drugs, reducing caffeine or nicotine intake, getting a massage, increasing healthy expression of anger) for reducing feelings of depression and anxiety; reinforce success in session.

8. Learn and implement relaxation techniques to reduce and manage anxiety symptoms. (22, 23, 24)

22. Teach the client relaxation skills (e.g., self-guided imagery, progressive muscle relaxation, deep rhythmic breathing) and how to apply these skills to his/her daily life; review and reinforce progress, problem solving obstacles.

23. Utilize biofeedback techniques to facilitate the client learning relaxation skills; monitor compliance and effectiveness while providing corrective feedback toward improvement.

24. Assign the client a homework exercise in which he/she practices daily relaxation techniques; review and reinforce success, providing corrective feedback toward success.

9. Learn and implement problem-solving strategies for realistically addressing worries. (25, 26)

25. Teach problem-solving strategies specifically defining a problem, generating options for addressing it, evaluating options, implementing a plan, and reevaluating and refining the plan.

26. Assign the client a homework exercise in which he/she solves a current problem (see *Mastery of Your Anxiety and Worry: Workbook,* 2nd ed. by Craske

and Barlow); review, reinforce success, and provide corrective feedback toward improvement.

10. Identify individuals that will offer physical and emotional support in times of distress. (27, 28, 29)

27. Offer a family or group therapy session to have the client communicate to his/her family or friends their experience with being a victim of stalking; educate family/friends on ways they can help protect and support the client.

28. Discuss with the client people to solicit for support at work (e.g., supervisor, employee assistance program personnel, security officers); review progress in session addressing resistance or noncompliance.

29. Encourage the client to communicate daily with support systems to reduce feelings of insecurity, paranoia, or anxiety; monitor the client's compliance in daily communication.

11. Identify, challenge, and replace self-blame with an understanding that the stalking is the responsibility of the stalker. (30, 31, 32)

30. When the client expresses guilt/self blame, redirect the client to view the stalking as a crime committed against himself/herself for which the stalker is to blame.

31. Confront and challenge any of the client's minimizing or making excuses regarding the seriousness of the stalking; assess if the client believes he/she is to blame for the stalking.

32. Assign the client a homework exercise in which he/she identifies himself/herself in self-talk to be to blame for stalking and create reality-based alternatives; review and reinforce success in sessions, providing corrective feedback for failure.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.24 | F43.22 | Adjustment Disorder, With Anxiety |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.28 | F43.23 | Adjustment Disorder, With Mixed Anxiety and Depressed Mood |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| V65.2 | Z76.5 | Malingering |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 296.xx | F33.x | Major Depressive Disorder, Recurrent Episode |
| V61.10 | Z63.0 | Relationship Distress with Spouse or Intimate Partner |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 295.70 | F25.0 | Schizoaffective Disorder, Bipolar Type |
| 295.70 | F25.1 | Schizoaffective Disorder, Depressive Type |
| 301.0 | F60.0 | Paranoid Personality Disorder |
| 301.83 | F60.3 | Borderline Personality Disorder |
| 301.6 | F60.7 | Dependent Personality Disorder |
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# SUDDEN / ACCIDENTAL DEATH (ADULT)

## BEHAVIORAL DEFINITIONS

1. Sudden death of a person (e.g., death from motor vehicle accident, shooting/homicide, assault and battery, drowning, workplace accident, or fire entrapment).
2. Recurrent, intrusive, traumatic memories, flashbacks, and nightmares (e.g., witnessing the death, receiving death notification) related to the death.
3. Difficulty in concentrating and following directions after the death.
4. Increased use of alcohol or other mood-altering substances following the death.
5. Experiencing suspicion and mistrust of others following the death to the point that it interferes with daily functioning.
6. Social withdrawal and isolation; avoidance of certain locations.
7. Inability to regulate emotions following the death.
8. Feelings of guilt regarding the death.
9. Disruption of typical eating habits and sleep patterns, as well as lack of personal hygiene following the death.
10. Physical symptoms such as chest pain, chest pressure, shortness of breath, muscle tension, headaches, intestinal upset, heart palpitations, and dry mouth.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore appropriate levels of affective, behavioral, and cognitive functioning.
3. Reduce physical complaints.
4. Develop a healthy grieving process.
5. Re-establish a sense of meaning for the future.
6. Re-establish healthy family relationships.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Cooperate with completing objective assessment instruments. (1) | 1. Administer to the client assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Trauma Symptom Checklist, Traumatic Life Events Questionnaire, Family Crisis Oriented Personal Evaluation Scales [F-COPE]) to guide intervention that is needed with the client. |
| 2. Control urges for aggressive or violent behaviors toward anyone associated with the death. (2, 3, 4, 5) | 2. Use de-escalation skills to prevent the client's aggressive or violent actions toward those associated with the death.<br>3. As appropriate, contact law enforcement or other trained individuals who can help behaviorally manage the client. |

4. Notify individuals that the client has verbally threatned to harm or kill as mandated by the legal system.
5. Educate the client that keeping feelings pent up has the potential of intensifying their anger to the point of he/she becoming destructive; encourage controlled expression of anger and openness to a balanced emotional perspective.

3. Secure medical treatment for acute physical reactions to the news that the person has died. (6)

6. Facilitate the client's access to emergency medical services or medical personnel as needed for complaints of chest pain or other acute medical conditions in reaction to the news that a death has occurred.

4. Say good-bye to and view the deceased's body. (7, 8)

7. Obtain information from medical personnel, law enforcement, or others regarding the appearance of the deceased's body (e.g., missing limbs, disfigurement, blood, contusions) and inform the client to prepare him/her psychologically for viewing the body.
8. Physically and emotionally support the client in viewing the deceased's body.

5. Make decisions regarding funeral/memorial service arrangements. (9)

9. Facilitate the client in making decisions and arrangements related to the funeral (e.g., burial, cremation, memorial service, making donations).

6. Learn and implement calming and coping strategies to manage the reactions to the death. (10)

10. Teach the client strategies from stress inoculation training such as relaxation, breathing control, covert modeling (e.g., imagining the successful use of the strategy), and/or role-playing

(e.g., with a therapist or trusted friend) for managing fears until a sense of mastery is evident.

7. Verbalize an understanding of emotional reactions that are typical responses to the incident. (11)

8. Allow the client to explore his/her perceptions of the incident. (12, 13, 14)

9. Talk with family, friends, and the community about the death. (15, 16, 17)

11. Assure the client that emotional reactions are expected and that there are no right or wrong feelings in the sudden death of a person.

12. Communicate support by maintaining eye contact with the client, speaking clearly and slowly, and at the same level (i.e., sitting or standing) as the client.

13. Use active listening and responding skills to explore the client's affective, behavioral, and cognitive reactions while he/she recounts the death in as much detail as he/she is comfortable with (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

14. Allow the client to articulate in a safe, nonthreatening environment the controlled expression of their feelings; correcting irrational perceptions of the incident.

15. Role-play with the client disclosing information about the person's death to different people in the community; process the reactions to the exercise.

16. Encourage and facilitate the client sharing affective and cognitive reaction with a professional therapist, family member, and/or trusted friend.

17. Offer to contact family, friends, or others (e.g., minister, pastor,

priest, rabbi) to ask them to come and provide support for the client.

10. Identify, challenge, and replace biased, fearful self-talk about the death with reality-based, healthy self-talk. (18, 19)

18. Assign the client homework (e.g., journaling, creating a list of five things) to identify fearful self-talk and to generate reality-based alternatives; review and reinforce success, providing corrective feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

19. Explore the client's schema and self-talk that mediates incident-related fears; challenge negative biases and assist him/her in generating appraisals that correct for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

11. Verbalize a reduced level of anxiety associated with talking about events surrounding the death. (20)

20. Have the client use imaginal exposure to events about the death by having him/her describe the experience at an increasing but client-chosen level of detail; repeat until associated anxiety reduces and stabilizes; review and reinforce progress, process reduction of problem solving obstacles.

12. Verbalize a resolution of irrational guilt feelings related to the death. (21, 22)

21. Explore the client's sense of guilt over the death.

22. Explore the client's regrets by asking about what he/she believes could have, should have, or would have been done; use cognitive restructuring to counteract unrealistic thoughts with alternate realistic thoughts.

13. Limit the time to focus on grieving the loss. (23, 24)

23. Suggest to the client to use symbolic healing tactics (e.g., sending balloons up in the air, writing a letter to the deceased) to represent the client letting go of the deceased.

24. Suggest a time-limited period be set aside each day for the client to focus on grieving the loss (e.g., 20 minutes in the morning); after the time is completed, direct the client to engage in routine daily activities.

14. Share some memories of the last contact with deceased. (25, 26)

25. Talk with the client about the last time he/she saw or spoke to the deceased; encourage the client to share what was discussed.

26. Explore with the client what he/she wished had been said to the deceased before the death. Utilize the empty chair technique to facilitate this discussion.

15. Visit the scene of the loved one's death. (27, 28, 29, 30)

27. If the deceased's body is unable to be viewed for investigative reasons or due to a grotesque condition, support the client in going to the location of the death after the body has been removed.

28. Educate the client that viewing the environment of his/her loved one's death helps to prevent distorted images in the future.

29. Accompany the client to the site where the death occurred and process his/her emotional reactions on site.

30. Provide space for the client to pace and move about that causes no disturbance to the integrity of the crime scene, residence, or other people who may be around.

16. Decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the death. (31)

31. Assess the client for increased use of alcohol and other mood-altering substances following the event that are used as a means of coping with the trauma; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary.

17. Family members use healthy communication skills when discussing the person's death. (32, 33)

32. Teach family members healthy communication skills (e.g., reflective listening, eye contact, respect, etc.) to be used when discussing the loved one's death.

33. Use modeling, role-playing, corrective feedback, and positive reinforcement to train the family in healthy communication skills including assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner.

18. Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within the family. (34, 35)

34. Assign the client or family members a homework exercise to use, monitor, and record newly learned communication skills; process results in session, providing corrective feedback toward improvement.

35. Assist the client or family members in identifying conflicts that can be addressed using communication, conflict-resolution, and/or problem-solving skills.

19. Learn and implement problem-solving and conflict-resolution skills. (36)

36. Teach the client and/or family members in problem-solving skills (e.g., pinpoint the problem, brainstorm possible solutions,

list the pros and cons of each solution, select and implement a solution, evaluate the outcome, modify the solution if necessary); role-play the application of this process to a family issue of conflict.

20. Identify positive consequences that may have resulted from the death. (37)

21. Return to typical daily routines in a timely manner. (38, 39)

22. Implement a plan of constructively reacting to the economic consequences of the death of a partner. (40, 41, 42)

37. Use reframing to help the client explore and identify positive changes (e.g., greater sense of independance, increased appreciation of future) associated with positive recovery and resiliency following a death of their loved one.

38. Inform the client about the importance of maintaining adequate eating and personal hygiene habits; help him/her plan ways to accomplish this.

39. Inquire about the client's sleeping patterns and suggest strategies to help him/her fall asleep (e.g., getting out of bed to read for a limited time if he/she cannot fall asleep).

40. Inquire regarding the economic impact of the death of the client's loved one has had on their financial status (e.g., loss of income, paying bills, mortgage, and so on).

41. Assist the client in identifying sources of economic support (e.g., life insurance, family and friends, government entitlement programs, and so on).

42. Ask the client to write a plan for ways to meet economic needs (e.g., selling the house, obtaining employment, and so on); review the plan with the client.

23. Begin the process of disposing of the deceased's belongings. (43)

24. Connect with community-based resources that can provide support in the grieving process. (44)

25. Agree to access mental health services if grieving interferes with daily functioning. (45, 46, 47)

26. Cooperate with an assessment to determine the presence or absence of an ongoing dysfunctional reaction to the trauma. (48, 49)

43. Explore the client's need to clean the deceased's room, take care of belongings, distribute clothes, and so on; recommend this process to be gradual to avoid feeling overwhelmed or regretting decisions that cannot be reversed.

44. Direct the client to community-based services (e.g., faith-based organizations, Mothers Against Drunk Driving, Victims of Violent Crime, grief support groups, online groups such as GriefNet.org and groww.org) for emotional support.

45. Educate the client about possible psychological complications (e.g., flashbacks, depression, suicidal ideations) to the sudden death of their loved one that would require additional intervention.

46. Provide the client with a list of available mental health referral resources.

47. Provide the client with pamphlets and other literature regarding grief and bereavement.

48. Administer to the client assessment instruments specifically designed for crisis and traumatic situations (e.g., Symptom Checklist–90–Revised, Global Appraisal of Individual Needs–Short Screener [GAIN-SS], General Anxiety Disorder–7 [GAD-7], Beck Depression Inventory–II) to monitor the recovery process.

49. Conduct suicide and homicide assessments with the client as needed.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| V62.89 | R41.83 | Borderline Intellectual Functioning |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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| _____ | _____ | _____ |

# SUDDEN / ACCIDENTAL DEATH (CHILD)

## BEHAVIORAL DEFINITIONS

1. Sudden death of a child (e.g., death from motor vehicle accident, shooting/homicide, assault and battery, drowning, school accident, or fire entrapment).
2. Sudden death of a child resulting from sudden infant death syndrome (SIDS).
3. Recurrent, intrusive, traumatic memories, flashbacks, and nightmares (e.g., witnessing the death, receiving death notification) related to the death.
4. Difficulty in concentrating and following directions after the death.
5. Increased use of alcohol or other mood-altering substances following the death.
6. Experiencing of suspiciousness and mistrust of others following the death to the point that it interferes with daily functioning.
7. Social withdrawal and isolation, avoidance of certain locations.
8. Inability to regulate emotions following the death.
9. Feelings of guilt regarding the death.
10. Significant change in family functioning.
11. Disturbance of caregivers' relationship.
12. Disruption of typical eating habits, sleep patterns, and lack of personal hygiene following the death.
13. Physical symptoms such as chest pain, chest pressure, shortness of breath, muscle tension, headaches, intestinal upset, heart palpitations, and dry mouth.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore appropriate levels of affective, behavioral, and cognitive functioning.
3. Reduce physical complaints.
4. Develop a healthy grieving process.
5. Re-establish a sense of meaning for the future.
6. Re-establish healthy family relationships.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
|---|---|
| 1. Cooperate with completing objective assessment instruments. (1) | 1. Administer to the caregivers assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Trauma Symptom Checklist, Traumatic Life Events Questionnaire, Family Crisis Oriented Personal Evaluation Scales [F-COPE]) to guide intervention. |
| 2. Verbalize an understanding that the child has died. (2) | 2. Make contact by maintaining eye contact with the caregivers and siblings, speaking clearly and slowly, and at the same level (i.e., sitting or standing) as the caregivers and siblings, give factual information about the death. |
| 3. Secure medical treatment for complications in the caregivers or siblings reactions to the news that the child has died. (3) | 3. Facilitate the caregivers' and siblings' gaining access to emergency medical services or medical personnel as needed for |

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| | complaints of chest pain or other acute medical conditions. |
| 4. Control urges for aggressive or violent behaviors toward anyone associated with the death. (4, 5) | 4. Use de-escalation skills to prevent aggressive or violent actions toward the medical staff or others associated with the death. |
| | 5. As appropriate, contact law enforcement or other trained individuals who can help behaviorally manage caregivers and siblings. |
| 5. Say good-bye to, view, and hold the child's body. (6, 7) | 6. Obtain information from medical personnel, law enforcement, or others regarding the appearance of the child's body (e.g., missing limbs, disfigurement, blood, contusions) and inform caregivers and siblings to prepare them psychologically for viewing the child's body. |
| | 7. Physically and emotionally support the caregivers and siblings in viewing the child's body. |
| 6. Engage in funeral and memorial service decision making. (8, 9) | 8. Use symbolic healing tactics (e.g., setting a plaque at the child's school, sending balloons up in the air, planting flowers, making donations) to represent letting go. |
| | 9. Facilitate caregivers and siblings in making decisions and arrangements related to the funeral (e.g., burial, cremation, memorial service). |
| 7. Communicate with the deceased's school regarding arrangements for the child's service and memorial. (10) | 10. Liaison with the child's school regarding the child's funeral and memorial service. |
| 8. Verbalize an understanding that emotional reactions to the sudden death of a child are expected. (11, 12) | 11. Educate caregivers and siblings that restricting the expression of feelings has the potential of intensifying their strength to the point of potentially becoming destructive. |

12. Assure client that there are no right or wrong feelings and that grief is a culturally learned experience.

9. Caregivers and siblings explore their perceptions of the death. (13, 14)

13. Use actual listening skills to explore the caregivers' and siblings' affective, behavioral, and cognitive reactions while they recount the death in as much detail as they are comfortable with (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

14. Support a controlled expression of feelings by caregivers and siblings about the child's death by placing limits on irrational perceptions about the death. Provide a safe, non-threatening setting for their feelings to be articulated.

10. Learn and implement soothing and coping strategies to manage the reactions to the death. (15, 16)

15. Teach the caregivers and siblings strategies from stress inoculation training such as relaxation, breathing control, covert modeling (e.g., imagining the successful use of the strategy), and/or role-playing (e.g., with a therapist or trusted friend) for managing fears about the death of the child until a sense of mastery is evident.

16. Use homework exercises to help caregivers and siblings identify fearful self-talk and create reality-based alternatives; review and reinforce success, and provide corrective feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

11. Identify the loss of hopes, dreams, and expectations for the child and family. (17)

17. Encourage the caregivers and siblings to talk to the deceased child, share their dreams, and

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| | say good-bye; utilize the empty chair technique. |
| 12. Identify, challenge, and replace biased, fearful self-talk related to the death of the child with reality-based, constructive self-talk. (18, 19) | 18. Explore the caregivers' and siblings' irrational thoughts and self-talk that result in fears associated with the death; challenge negative biases and assist in generating realistic appraisals that correct for the biases in order to build confidence in self (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| | 19. Have caregivers and siblings use imaginal exposure to events about the child's death by having him/her to describe their experience at an increasing but client-chosen level of detail; repeat the exercise to reduce the associated anxiety until it stabilizes; review and reinforce progress, review and reduce problem-solving obstacles. |
| 13. Caregivers and siblings talk with family, friends, and the community about the death. (20, 21) | 20. Role-play with the caregivers and siblings discussing the child's death to different people in the community such as a trusted friend or other family member. Process the reactions to the exercise. |
| | 21. Offer to contact family, friends, or others (e.g., minister, pastor, priest, rabbi) to ask them to come and provide support for caregivers and siblings. |
| 14. Verbalize a resolution of irrational guilt feelings related to the death. (22, 23) | 22. Discuss caregiver's and sibling's sense of loss by disputing a sense of guilt over the death. |
| | 23. Explore with caregivers and siblings what they wished had been said to the child before the death; utilize the empty chair |

technique to facilitate this discussion.

15. Openly share memories of the child. (24)

24. Asks the caregivers and siblings to describe happy, sad, and angry memories of the child. Yearbooks, degrees, awards, and so on may be used to facilitate this discussion. Process the memories and the pain associated with them.

16. Limit the time to focus on grieving the loss. (25)

25. Suggest a time-limited period and place be set aside each day to focus on the loss (e.g., 20 minutes in the morning and a specific location). After the time is completed client(s) will engage in routine daily activities.

17. Maintain focus on the present rather than the past or future. (26)

26. Acknowledge the desire for answers, but redirect caregivers and siblings from focusing on *why* questions to identify the affect behind the questions.

18. Visit the scene of the child's death. (27, 28, 29)

27. If the child's body is unable to be viewed for investigative reasons or due to a grotesque condition, support caregivers and siblings in going to the location of the death after the body has been removed.

28. Educate the caregivers and siblings that viewing the environment of the child's death helps to prevent distorted images in the future.

29. Accompany caregivers and siblings to the site where the child's death occurred and process emotional reactions on site. Allow caregivers and siblings to move about without disturbing the integrity to the crime scene or others people who may be around.

19. Family members use healthy communication skills when

30. Meet with family members to teach them constructive

discussing the child's death. (30, 31)

communication skills (e.g., reflective listening, eye contact, respect, etc.) to be used when discussing the child's death.

31. Use behavioral techniques (modeling, role-playing, corrective feedback, and positive reinforcement) to teach the family communication skills including assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner.

20. Increase the frequency of the direct expression of honest, respectful, and positive feelings and thoughts within the family. (32, 33)

32. Use a chart in order to assist the family in monitoring newly learned communication skills; process results in session, providing corrective feedback toward improvement.

33. Assist the family in identifying conflicts associated with the child's death that can be addressed using healthy communication, conflict-resolution, and/or problem-solving skills.

21. Learn and implement problem-solving and conflict-resolution skills. (34)

34. Teach the family problem-solving skills (e.g., pinpoint the problem, brainstorm possible solutions, list the pros and cons of each solution, select and implement a solution, evaluate the outcome, modify the solution if necessary); role-play the application of this process to family issues related to recovering from the death of the child.

22. Identify positive consequences that may have resulted from the child's death. (35)

35. Identify positive changes (e.g., closer family relationships, increased appreciation of future) associated with positive recovery and resiliency following the sudden death of a child.

23. Begin the process of disposing of the child's belongings. (36)

24. Restore to daily routines through returning to normal operations in a timely manner. (37)

25. Caregivers and siblings connect with community-based resources that can provide support in recovery from the death of the child. (38)

26. Decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the event. (39)

27. Contact mental health providers if grief-related problems interfere with daily functioning. (40, 41, 42)

36. Explore the caregiver and sibling's need to clean the child's room, take care of their belongings, distribute clothes, and so on. Recommend this process to be gradual to avoid feeling overwhelmed or regretting decisions that cannot be reversed.

37. Educate caregivers and siblings about the importance of maintaining adequate eating, personal hygiene habits, and regular sleeping patterns. Suggest ways to maintain these such as journaling and relaxation techniques.

38. Direct caregivers and siblings to community-based services (e.g., faith-based institutions, SIDS support groups in community or online, Mothers Against Drunk Driving, local smoke detector programs) for emotional support.

39. Assess the caregivers and siblings for increased use of alcohol and other mood-altering substances following the event that are used as a means of coping with the trauma; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary.

40. Educate the caregivers and siblings about possible psychological complications (e.g., flashbacks, depression, suicidal ideations) to the sudden death of a child that would require additional intervention.

41. Provide lists of available mental health referral resources to the caregivers and siblings.

42. Provide to the caregivers and siblings pamphlets and other

literature regarding grief and bereavement.

28. Caregivers and siblings complete objective instruments to determine the presense or absense of ongoing dysfunctional reactions as they adjust to the child's death. (43, 44)

43. Administer to the caregivers and siblings assessment instruments specifically designed for crisis and traumatic situations (e.g., Symptom Checklist–90–Revised, Global Appraisal of Individual Needs–Short Screener [GAIN-SS], General Anxiety Disorder–7 [GAD-7], Beck Depression Inventory–II) to monitor the recovery process.

44. Conduct suicide and homicide assessments with the caregivers and siblings as needed.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| V62.89 | Z65.8 | Religious or Spiritual Problem |
| V61.10 | Z63.0 | Relationship Distress With Spouse or Intimate Partner |
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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# SUICIDE (ADULT)

## BEHAVIORAL DEFINITIONS

1. Suicide of spouse.
2. Suicide of extended family member or friend.
3. Recurrent, intrusive, traumatic memories, flashbacks, and nightmares (e.g., discovering the body, receiving notification) related to suicide.
4. Difficulty in concentrating and following directions after the suicide.
5. Increased use of alcohol or other mood-altering substances following the suicide.
6. Experiencing of suspiciousness and mistrust of others following the suicide to the point that it interferes with daily functioning.
7. Social withdrawal and isolation; avoidance of certain locations.
8. Inability to regulate emotions following the suicide.
9. Feelings of guilt regarding following the suicide.
10. Disruption of typical sleep patterns following the suicide.
11. Physical symptoms such as chest pain, chest pressure, shortness of breath, muscle tension, headaches, intestinal upset, heart palpitations, and dry mouth.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning including resumption of routine daily activities.

2. Restore appropriate levels of affective, behavioral, and cognitive functioning.
3. Reduce physical complaints.
4. Develop a healthy grieving process.
5. Re-establish a sense of meaning for the future.
6. Re-establish healthy family relationships

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
|---|---|
| 1. Cooperate with completing objective assessment instruments. (1) | 1. Administer to the client assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Trauma Symptom Checklist, Traumatic Life Events Questionnaire, Family Crisis Oriented Personal Evaluation Scales [F-COPE]) to guide intervention. |
| 2. Verbalize an understanding that emotional reactions are expected responses to the suicide of a loved one. (2) | 2. Reassure the client that emotional reactions are expected in this incident and assure client that there are no right or wrong feelings. |
| 3. Verbalize an understanding that the person has committed suicide. (3) | 3. Establish rapport through eye contact with the client, speaking clearly and slowly, and at the same level (i.e., sitting or standing) as the client. |
| 4. Share suicide note in private setting. (4) | 4. Read the suicide note with the client and provide affective, behavioral, and cognitive support as it is analyzed for |

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| | dysfunctional thinking, blaming, despair, hurt, and/or anger. |
| 5. Allow the client to explore his/her perceptions of the incident. (5, 6) | 5. Use active listening skills to explore the client's affective and cognitive reactions while they recount the suicide in as much detail as they are comfortable with (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| | 6. Facilitate the client's controlled expression of feelings by placing limits, allowing them to be articulated in a safe, non-threatening manner. |
| 6. Talk with trusted family and friends about the suicide. (7, 8) | 7. Encourage and facilitate the client's sharing of their affective, behavioral, and cognitive reactions with a professional therapist, family member, and/or trusted friend. |
| | 8. Practice disclosing information about the person's suicide to family and friends; process the reactions to the exercise with the client. |
| 7. Decrease reliance on self-medication through the use of alcohol or other mood-altering substance as a way to cope with the event. (9) | 9. Assess the client for increased use of alcohol and other mood-altering substances following the event, which are used as a means of coping with the trauma; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary. |
| 8. Learn and apply calming and coping strategies to manage the reactions to the suicide. (10) | 10. Teach the client strategies to manage fears using stress inoculation training such as relaxation, breathing control, covert modeling (e.g., imagining the successful use of the strategy), and/or role-playing |

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| | (e.g., with a therapist or trusted friend). |
| 9. Identify, challenge, and replace biased, fearful self-talk about the suicide with reality-based, positive self-talk. (11, 12) | 11. Assign the client a homework exercise (e.g., journaling) in which he/she identifies fearful self-talk and assist him/her to develop reality-based alternatives; review and reinforce success, providing corrective feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| | 12. Explore the client's thought processes and self-talk that mediates suicide-related fears; challenge negative biases and assist him/her in generating appraisals that correct for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| 10. Verbalize a reduced level of anxiety associated with talking about events surrounding the death. (13) | 13. Have the client describe events about the suicide by having him/her imagine the experience at an increasing but client-chosen level of detail; repeat this exposure until associated anxiety reduces and stabilizes; review and reinforce progress, problem, and reduction of problem-solving obstacles. |
| 11. Connect to healthy, constructive social interactions in order to prevent isolation and build self-esteem. (14) | 14. Assist the client(s) in making arrangements for social opportunities (e.g., luncheons) as appropriate to interact with family and friends. |
| 12. Attend a self-help group for support with grief and reduce confusion related to the suicide. (15) | 15. Direct the client to community-based and online self-help groups (e.g., faith-based institutions, Survivors of Suicide, Alliance of |

Hope for Suicide Survivors, The American Association of Suicidology).

13. Verbalize a resolution of irrational guilt feelings related to the death. (16)
14. Maintain focus on present rather than the past or future. (17, 18)
15. Share some memories of the last contact with deceased. (19)
16. Express thoughts and feelings that were disappointedly left unexpressed to the deceased. (20)
17. Make arrangements regarding funeral/memorializing activities. (21, 22)
18. Limit the time to focus on grieving the loss. (23)

16. Discuss the client's sense of loss by disputing a sense of guilt over the suicide.
17. Discuss with the client regrets by asking about what he/she believes could have, should have, or would have been done differently.
18. Acknowledge the desire for answers but redirect the client from focusing on *why* questions to identify the affect behind the questions.
19. Talk with the client/family about the last time he/she saw or spoke to the deceased; encourage the client/family to share what was discussed.
20. Explore with the client what he/she wished had been said to the person before their suicide; utilize the empty chair technique to facilitate this discussion.
21. Use symbolic healing tactics (e.g., writing a farewell letter, planting flowers, making donations) to represent letting go.
22. Facilitate client in making decisions and arrangements related to the funeral (e.g., burial, cremation, memorial service).
23. Suggest to the client that a time-limited period and place be set aside each day to focus on the loss (e.g., 20 minutes in the morning in a specified location). After the time is completed, the client will engage in daily activities.

19. Implement a plan of constructively reacting to the economic consequences of the death of a loved one. (24, 25, 26)

24. Inquire regarding the economic impact of the suicide (e.g., loss of income, paying bills, mortgage, and so on).

25. Assist the client in identifying sources of economic support (e.g., life insurance, family and friends, government entitlement programs, and so on).

26. Ask the client to write a plan on ways to meet economic needs (e.g., selling the house, obtaining employment, and so on); review the plan with the client.

20. Help the client return to typical daily routines through returning to normal operations in a timely manner. (27)

27. Educate the client about the importance of maintaining healthy eating, personal hygeine habits, resuming pre-suicide activities of daily living; suggest ways to maintain these such as journaling and relaxation techniques.

21. Begin the process of disposing of the person who committed suicide belongings. (28)

28. Explore the client's need to clean the room of the person that committed suicide, take care of belongings, distribute clothes, and so on; recommend this process to be gradual to avoid feeling overwhelmed or regretting decisions that cannot be reversed.

22. Family members share their memories of the deceased. (29)

29. Conduct a family session in which all members share memories they have of the person; process the joy and pain in these memories.

23. Family members use healthy communication skills when discussing the suicide. (30, 31, 32)

30. Teach family members healthy communication skills (e.g., reflective listening, eye contact, respect, etc.) to be used when discussing the suicide.

31. Use modeling, role-playing, corrective feedback, and positive

reinforcement to coach the family members in using communication skills including assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner.

32. Assign the family a homework exercise to use, monitor, and record newly learned communication skills; process results in session, providing corrective feedback toward improvement.

24. Learn and implement problem-solving and conflict-resolution skills for issues within the family related to the suicide. (33, 34)

33. Assist the family in identifying conflicts that can be addressed using healthy communication, conflict-resolution, and/or problem-solving skills to relieve stress related to the suicide.

34. Teach the family problem-solving skills (e.g., pinpoint the problem, brainstorm possible solutions, list the pros and cons of each solution, select and implement a solution, evaluate the outcome, modify the solution if necessary); role-play the application of this process to a family issue of conflict associated with issues surrounding the suicide.

25. Agree to access mental health services if grieving interferes with daily functioning. (35, 36, 37)

35. Educate the client about possible psychological complications (e.g., flashbacks, depression, suicidal ideations) to the traumatic death that would require additional intervention.

36. Provide the client with a list of available mental health referral resources.

37. Provide the client with pamphlets and other literature regarding recovery from the suicide.

26. Cooperate with an assessment to determine the presence or absence of an ongoing dysfunctional reaction to the suicide of a loved one or friend. (38, 39)

38. Administer to the client assessment instruments specifically designed for crisis and traumatic situations (e.g., Symptom Checklist–90–Revised, General Anxiety Disorder–7 [GAD-7], Beck Depression Inventory–II) to monitor the recovery process.

39. Conduct suicide and homicide assessments with the client as needed.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| V62.89 | Z65.8 | Religious or Spiritual Problem |
| 296.2x | F32.x | Major Depressive Disorder, Single Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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# SUICIDE (CHILD)

## BEHAVIORAL DEFINITIONS

1. Suicide of own child, sibling, or young family member.
2. Suicide of student, youth athlete, or neighbor child.
3. Recurrent, intrusive, traumatic memories, flashbacks, and nightmares (e.g., discovering the body, receiving notification) related to a child's suicide.
4. Difficulty in concentrating and following directions after the suicide.
5. Increased use of alcohol or other mood-altering substances following the suicide.
6. Experiencing of suspiciousness and mistrust of others following the suicide to the point that it interferes with daily functioning.
7. Social withdrawal and isolation; avoidance of certain locations.
8. Inability to regulate emotions following the suicide.
9. Feelings of guilt regarding following the suicide.
10. Disruption of typical sleep patterns following the suicide.
11. Physical symptoms such as chest pain, chest pressure, shortness of breath, muscle tension, headaches, intestinal upset, heart palpitations, and dry mouth.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore appropriate levels of affective, behavioral, and cognitive functioning.
3. Reduce physical complaints.
4. Develop a healthy grieving process.
5. Re-establish a sense of meaning for the future.
6. Re-establish healthy family relationships.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Cooperate with completing objective assessment instruments. (1) | 1. Administer to the caregivers and siblings assessment instruments specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Trauma Symptom Checklist, Traumatic Life Events Questionnaire, Family Crisis Oriented Personal Evaluation Scales [F-COPE]) to guide intervention that is needed. |
| 2. Verbalize that emotional reactions are typical responses to the incident. (2) | 2. Reassure the caregivers and siblings that emotional reactions are expected in this incident and assure client that there are no right or wrong feelings. |
| 3. Verbalize an understanding that the child has committed suicide. (3) | 3. Communicate support by appropriately maintaining eye contact with the caregivers and |

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| | siblings, speaking clearly and slowly, and at the same level (i.e., sitting or standing) as the client; communicate slowly but directly that the child has committed suicide and understand the need to repeat the message several times. |
| 4. Share suicide note in private setting. (4) | 4. Read the suicide note with the caregivers and siblings and provide affective, behavioral, and cognitive support as it is analyzed for dysfunctional thinking, blaming, despair, hurt, and/or anger. |
| 5. Allow the caregivers and siblings to explore their perceptions of the incident. (5, 6) | 5. Explore the caregivers' and siblings' affective, behavioral, and cognitive reactions while they recount the suicide in as much detail as they are comfortable with (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).<br>6. Facilitate the caregivers' and siblings' controlled expression of feelings by placing limits, allowing them to be articulated in a safe, non-threatening manner. |
| 6. Caregivers and siblings talk with family, friends, and the community about the suicide. (7, 8) | 7. Validate and facilitate the caregivers' and siblings' sharing of their affective, behavioral, and cognitive reactions with a professional therapist, family member, and/or trusted friend.<br>8. Role-play with the caregivers and siblings disclosing information about the child's death to different people in the community. Process the reactions to the exercise. |

7. Decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the event. (9)

8. Learn and implement calming and coping strategies to manage the reactions to the suicide. (10)

9. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (11, 12)

10. Verbalize a reduced level of anxiety associated with talking about events surrounding the death. (13)

9. Assess the caregivers and siblings for increased use of alcohol and other mood-altering substances following the event that are used as a means of coping with the trauma; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary.

10. Teach the caregivers and siblings to manage their fears about the suicide using stress inoculation strategies such as relaxation, breathing control, covert modeling (e.g., imagining the successful use of the strategy), and/or role-playing (e.g., with a therapist or trusted friend).

11. Assign the caregivers and siblings a homework exercise to compile a list of fearful self-talk related to the suicide and then to develop reality-based alternatives; review and reinforce success, providing corrective feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

12. Explore the caregiver's and sibling's schema and self-talk that exaggerates suicide-related fears; challenge negative biases and assist him/her in generating appraisals that correct for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma).

13. Have the caregivers and siblings undergo imaginal exposure to events about the suicide by having him/her describe the

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| | experience at an increasing but client-chosen level of detail; repeat until associated anxiety reduces and stabilizes; review and reinforce progress, review and reduce problem-solving obstacles. |
| 11. Return to typical daily routines in a timely manner. (14) | 14. Educate the caregivers and siblings about the importance of maintaining adequate eating, personal hygiene habits, and restful sleeping patterns; suggest ways to maintain these such as journaling and relaxation techniques. |
| 12. Caregivers and siblings connect with community-based resources that can provide grief support. (15) | 15. Direct the caregivers and siblings to community-based and online self-help groups (e.g., faith-based institutions, Survivors of Suicide, Alliance of Hope for Suicide Survivors, Compassionate Friends) for dealing with grief. |
| 13. Verbalize a resolution of irrational guilt feelings related to the death. (16, 17) | 16. Discuss the caregivers' and siblings' sense of loss by disputing a sense of guilt over the suicide. |
| | 17. Explore the caregivers' and siblings' regrets by asking about what they believe could have, should have, or would have been done differently. |
| 14. Maintain focus on the present rather than the past or future. (18) | 18. Acknowledge the desire for answers, but redirect the caregivers and siblings from focusing on *why* questions to identify the affect behind the questions. |
| 15. Share some memories of the last contact with deceased. (19) | 19. Talk with the caregivers and siblings about the last time they saw or spoke to the deceased. Encourage the clients to share what was discussed. |

16. Express thoughts and feelings that were disappointedly left unexpressed to the deceased. (20)

17. Verbalize an acceptance of the reality of the death, engaging in gestures of remembering and memorializing the deceased and arranging for the funeral. (21, 22)

18. Communicate with the deceased's school regarding arrangements for the child's service and memorial. (23)

19. Limit the time to focus on grieving the loss. (24)

20. Begin the process of disposing of the child's belongings. (25)

21. Openly share memories of the child. (26, 27, 28)

20. Explore with the caregivers and siblings what they wished had been said to the child before their suicide; utilize the empty chair technique to facilitate this discussion.

21. Use symbolic healing tactics with the caregivers and siblings (e.g., sending balloons up in the air, planting flowers, making donations) to represent letting go.

22. Facilitate the caregivers and siblings in making decisions and arrangements related to the funeral (e.g., burial, cremation, memorial service).

23. Liaison with the deceased's school to communicate the caregiver's wishes regarding issues related to the child's funeral and memorial service.

24. Suggest a time-limited period and place be set aside each day for the caregivers and siblings to focus on the loss (e.g., 20 minutes in the morning in a specified location). After the time is completed, client(s) will engage in daily activities.

25. Explore the caregiver's need to clean the child's room, take care of belongings, distribute clothes, and so on; recommend this process to be gradual to avoid feeling overwhelmed or regretting decisions that cannot be reversed.

26. Ask the caregivers and siblings to describe happy, sad, and angry memories of the child; process the memories and the pain associated with them.

22. Identify the loss of hopes, dreams, and expectations for the child and family. (29)

23. Family members use healthy communication skills when discussing the traumatic event. (30, 31, 32)

24. Learn and implement problem-solving and conflict-resolution skills for issues with the family related to the suicide. (33, 34)

27. Ask the caregivers and siblings to bring a yearbook, degrees, photos, awards, and so on in order to share the life and achievements of the child.

28. Conduct family sessions in which all members share their memories of the child and their emotional reaction to the suicide.

29. Explore the future plans that were imagined; empathizing with the lost dreams.

30. Teach family members healthy communication skills (e.g., reflective listening, eye contact, respect, etc.) to be used when discussing the suicide.

31. Teach the family members communication skills including assertive communication, offering positive feedback, active listening, making positive requests of others for behavior change, and giving negative feedback in an honest and respectful manner, using strategies such as role-play, corrective feedback, and positive reinforcement.

32. Assign the family a homework exercise to use and monitor newly learned communication skills; process results in session, providing corrective feedback toward improvement.

33. Assist the family in identifying conflicts that can be addressed using healthy communication, conflict-resolution, and/or problem-solving skills.

34. Teach the family problem-solving skills (e.g., pinpoint the

problem, brainstorm possible solutions, list the pros and cons of each solution, select and implement a solution, evaluate the outcome, modify the solution if necessary); role-play the application of this process to a family issue of conflict.

25. Agree to contact mental health providers if grief-related problems interfere with daily functioning. (35, 36, 37)

35. Educate the family about possible psychological complications (e.g., flashbacks, depression, suicidal ideations) to the suicide of a child that would require additional intervention.

36. Provide the caregivers with a list of available mental health referral resources.

37. Provide caregivers and siblings with (age appropriate) pamphlets and other literature regarding recovery from the suicide.

26. Caregivers and siblings cooperate in completing objective assessment instruments to evaluate their adjustment to the child's death. (38, 39)

38. Administer to the caregivers and siblings assessment instruments specifically designed for crisis and traumatic situations (e.g., Symptom Checklist–90–Revised, Global Appraisal of Individual Needs–Short Screener [GAIN - SS], General Anxiety Disorder–7 [GAD-7], Beck Depression Inventory–II) to monitor their cognitive and emotional reactions in the recovery process.

39. Conduct suicide and homicide assessments with the caregivers and siblings as needed.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| V62.82 | Z63.4 | Uncomplicated Bereavement |
| V61.20 | Z62.820 | Parent-Child Relational Problem |
| V62.89 | Z60.0 | Phase of Life Problem |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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# WORKPLACE VIOLENCE

## BEHAVIORAL DEFINITIONS

1. Physical assault of a fellow employee has occurred at work.
2. Shooting, robbery, or other violent crime was committed at the workplace.
3. Violence involving one employee with another or domestic dispute incident at a work site.
4. Recurrent, intrusive, traumatic memories, flashbacks, and nightmares related to trauma.
5. Preoccupation with suicidal or homicidal ideations following the trauma.
6. Difficulty in concentrating and following directions after the trauma.
7. Increased use of alcohol or other mood-altering substances following the incident.
8. Experiences dissociative symptoms of numbing, detachment, derealization, depersonalization, amnesia, or reduction of awareness to surroundings.
9. Marked avoidance of stimuli that arouse recollections of the trauma, whether through thoughts, feelings, conversations, activities, places, or people.
10. Absenteeism, tardiness, and/or self-report of discomfort/emotional distress while at the work site.
11. Persistent fear of death or personal injury occurring to self.
12. Experiences suspiciousness and mistrust of others following the crime to the point that it interferes with daily functioning.
13. Social withdrawal and isolation; avoidance of certain locations.
14. Unable to regulate emotions following the trauma.
15. Feels guilt regarding having survived the trauma in which others died.
16. Disruption of typical eating, sleeping, and personal hygiene patterns following the trauma.
17. Symptoms of increased arousal such as difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, or motor restlessness.

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## LONG-TERM GOALS

1. Return to pre-crisis level of functioning, including resumption of routine daily activities.
2. Restore appropriate levels of affective, cognitive, and behavioral functioning.
3. Return of a sense of safety to self.
4. Re-establish healthy and appropriate work and social relationships.
5. Termination of intrusive images related to stimuli associated with the workplace violence.
6. Assimilate the traumatic event into life experience without ongoing distress.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Secure medical care for any injury resulting from the incident. (1) | 1. Assist the client in receiving medical attention from Emergency Medical Personnel, Urgent Care facility, or Emergency Room or refer to physician for evaluation and treatment. |
| 2. Cooperate with an assessment of affective, behavioral, and | 2. Administer to the client assessment instruments |

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| cognitive reactions to the incident. (2) | specifically designed for crisis and traumatic situations (e.g., Triage Assessment Form: Crisis Intervention–Revised, Impact of Event Scale–Revised, Traumatic Life Events Questionnaire) to guide interventions. |
| 3. Recall the incident as accurately as possible, minimizing distortions resulting from affective or cognitive reactions. (3, 4, 5) | 3. Provide support to the client by using active listening and responding skills to explore affective, behavioral, and cognitive reactions. Speak slowly, be prepared to repeat inquires, and assure the client of his/her safety as appropriate.<br>4. Prompt the client to describe the traumatic experience, assessing whether he/she is overwhelmed with affect or cognitive reactions to the incident.<br>5. Consult with law enforcement officials, family, or friends who have facts regarding the crime to corroborate and/or elaborate the client's story. |
| 4. Explore perceptions of the incident; including the nature of the relationship between the client and the person who was violent. (6, 7, 8) | 6. Reassure the client that that there are no right or wrong feelings and validate his/her emotional reactions.<br>7. Educate the client that keeping feelings pent up has the potential of intensifying their emotional reactions to the point of potentially becoming destructive; facilitate expression of feelings associated with the job loss.<br>8. Inquire as to the nature of the client's relationship with the person who was violent; acknowledging the client's expressions indicating pre-violence indications of the perpetrators intent to commit the violent act. |

5. Describe a realistic, nonjudgmental perspective of own performance during the workplace incident. (9, 10)

6. Decrease reliance on self-medication through the use of alcohol or other mood-altering substances as a way to cope with the crisis. (11)

7. Identify, challenge, and replace biased, fearful self-talk with reality-based, calming and positive self-talk about the client's reactions during violent incident. (12, 13, 14)

9. Confront the client's negative evaluation of his/her performance during the incident and redirect him/her toward realistic perceptions by focusing on the facts of what took place and his/her response.

10. Aid the client in organizing his/her thoughts about the event and use cognitive behavioral techniques such as positive self-talk to build confidence about his/her performance in the incident.

11. Assess the client for increased use of alcohol and other mood-altering substances following the job loss that are used as a means of coping with the crisis; continue to monitor and discourage this maladaptive coping behavior, referring for addiction treatment if necessary.

12. Teach the client stress reduction strategies such as relaxation, breathing control, and/or covert modeling (e.g., imagining the successful use of the strategy), for managing their fears.

13. Challenge the client's negative biases and unhealthy self-talk by assisting him/her in generating appraisals that correct for the biases and build confidence (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

14. Assign the client a homework exercise (e.g., journaling) in which he/she identifies fearful self-talk and creates reality-based alternatives; review and reinforce success, providing corrective

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| | feedback for failure (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma). |
| 8. Participate in imaginal and in vivo exposure to workplace violence-related memories until thinking about the trauma does not result in marked distress. (15, 16, 17) | 15. Direct and assist the client in constructing a fear and avoidance hierarchy of workplace violence-related stimuli.<br>16. Assign the client homework exercises to monitor and record responses to stimuli associated with the violent incident.<br>17. Have the client undergo imaginal exposure to the workplace violence by having him/her describe their experience at an increasing but client-chosen level of detail; repeat until anxiety reduces and stabilizes. |
| 9. Learn and implement thought-stopping to manage intrusive unwanted thoughts. (18) | 18. Teach the client thought-stopping, in which he/she internally voices the word *STOP* and/or images something representing the concept of stopping (e.g., stop sign or red light) immediately upon noticing unwanted violence or otherwise negative unwanted thoughts. |
| 10. Verbalize an accurate understanding of posttraumatic stress disorder (PTSD) and its development. (19, 20) | 19. Educate the client about the development of PTSD from being exposed to a traumatic event that results in intrusive recollections, unwarranted fears, anxiety, and a vulnerability to other negative effects such as shame, anger, and guilt.<br>20. Assign the client to read psycho-educational chapters, books, or treatment manuals on PTSD that explains its features, development, and treatment. |
| 11. Maintain focus on the present rather than the violent incident. (21) | 21. Redirect the client's desire for answers to *why* questions to focus on affect behind the questions. |

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| 12. Identify areas of growth that have emerged from the incident. (22) | 22. Use reframing with the client to explore and identify positive changes (e.g., closer family relationships, increased appreciation of coworker bonds) associated with positive recovery and resiliency following a workplace violence incident. |
| 13. Return to typical daily routines in a timely manner. (23, 24, 25) | 23. Educate the client about the importance of maintaining adequate eating, and personal hygiene habits as well as healthy sleeping patterns; suggest ways to maintain these such as recording when the activities are completed each day. |
| | 24. Encourage the client to return to the work routine; if necessary, phasing into these activities gradually. |
| | 25. Accompany the client to the scene of the violence at the workplace while offering desensitization techniques to reduce the perception of threat and stress as these develop. |
| 14. Cooperate with an evaluation for psychotropic medications. (26) | 26. Refer the client to a doctor for an assessment to determine his/her need for medication to relieve symptoms of anxiety. |
| 15. Take medication as prescribed and report as to effectiveness and side effects. (27) | 27. Monitor the client's compliance with prescribed medication and sensitize him/her to potential side effects; report any significant reactions to the prescribing doctor. |
| 16. Implement regular exercise regimen. (28) | 28. Develop and encourage the client to engage in a routine of physical exercise as a stress release technique. |
| 17. Attend a memorial service for fellow employee(s). (29) | 29. Encourage the client to attend a funeral/memorial service for |

fellow employee(s) who was killed during the incident.

18. Managers verbalize an understanding of severe posttraumatic stress reactions. (30, 31)

30. Educate company managers of psychological problems such as posttraumatic stress reactions associated with poor recovery from a workplace violence event.

31. Provide basic training pamphlets or other literature to managers on active listening skills in order to assist employees in reducing stress.

19. Managers revise safety procedures to reduce the likelihood of a similar incident of violence in the future. (32, 33)

32. Facilitate a discussion between management and staff regarding the incident; focus on developing new security measures that would prevent future incidents (e.g., installing metal detectors and panic buttons, hiring security guards, performing criminal investigations of job applicants).

33. Assist the employer in reviewing and revising the implementation of safety, communication, and workplace crisis plans (e.g., communication procedures, moving employees to safety, writing notification memos, talking with media, involvement of outside agencies, relationship with law enforcement); communicate any changes to employees.

20. Agree to access mental health services if trauma reactions interfere with daily functioning. (34, 35, 36)

34. Inform the client of possible psychological complications (e.g., flashbacks, depression, suicidal ideations) to the workplace violence event that would require additional intervention.

35. Provide the client with a list of available mental health referral resources.

21. Cooperate with ongoing assessment of adjustment to the traumatic incident. (37, 38)

36. Provide the client with pamphlets and other literature regarding emotional reactions to workplace violence.

37. Administer to the client assessment instruments specifically designed for crisis and traumatic situations (e.g., Trauma Symptom Inventory–2, Symptom Checklist–90–Revised, Trauma Symptom Checklist) to monitor the recovery process.

38. Conduct suicide and homicide assessments with the client as needed.

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## DIAGNOSTIC SUGGESTIONS

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| V62.2 | Z56.9 | Other Problem Related to Employment |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 300.12 | F44.0 | Dissociative Amnesia |
| 300.14 | F44.81 | Dissociative Identity Disorder |
| 300.6 | F48.1 | Depersonalization/Derealization Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 308.3 | F43.0 | Acute Stress Disorder |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
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# Appendix A

# BIBLIOTHERAPY SUGGESTIONS

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# Appendix B

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# Appendix C

# OBJECTIVE INSTRUMENTS

## Acute Stress Disorder

*Dissociative Experiences Scale.* Carlson, E., & Putnam, F. (1986). Beloit, WI: Eve Bernstein Carlson, Department of Psychology, Beloit College.

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*Beck Depression Inventory–II.* Beck, A. (1996). San Antonio, TX: Pearson Education.

*General Anxiety Disorder–7 (GAD-7)*. (2006). Spitzer, R., Kroenke, K., Williams, J., & Lowe, B. New York, NY: Pfizer.

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## Child Abuse/Neglect

*Child Behavior Checklist.* Achenbach, T. (1991). Burlington, VA: University of Vermont.

*Childhood Trauma Questionnaire.* Bernstein, D., & Fink, L. (1994). San Antonio, TX: The Psychological Corporation.

*Reynolds Child Depression Scale.* Reynolds, W. (1986). Simi Valley, CA: Psychological Publication, Inc.

*Trauma Symptom Checklist for Children*. Briere, J. (1996). Odessa, FL: Psychological Assessment Resources (PAR).

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*Symptom Checklist–90–Revised*. Derogatis, L. (1994). San Antonio, TX: Pearson Education.

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*Beck Depression Inventory–II.* Beck, A. (1996). San Antonio, TX: Pearson Education.

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*Beck Depression Inventory–II.* Beck, A. (1996). San Antonio, TX: Pearson Education.

*Beck Hopelessness Scale.* Beck, A. (1993). San Antonio, TX: Pearson Education.

*Patient Health Questionnaire.* Spitzer, J., Williams, B., Kroenke, K., & colleagues. (1999). New York, NY: Pfizer.

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*Family Crisis Oriented Personal Evaluation Scales [F-COPE].* McCubbin, H. I., Olson, D. H., & Larsen, A. S. (1991). Madison, WI: Family Stress Coping and Health Project, University of Wisconsin–Madison.

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*Beck Depression Inventory–II.* Beck, A. (1996). San Antonio, TX: Pearson Education Inc.

*Family Crisis Oriented Personal Evaluation Scales [F-COPE]*. McCubbin, H. I., Olson, D. H., & Larsen, A. S. (1991). Madison, WI: Family Stress Coping and Health Project, University of Wisconsin–Madison.

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*Symptom Checklist–90–Revised.* Derogatis, L. (1994). San Antonio, TX: Pearson Education.

*Trauma Symptom Checklist.* Briere, J., & Runtz, M. (1989), http://www.johnbriere.com/tsc.htm.

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## School Trauma (Elementary)

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*Reynolds Child Depression Scale*. Reynolds, W. M. (1989). Odessa, FL: Psychological Assessment Resources.

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*General Anxiety Disorder-7 (GAD-7)*. (2006). Spitzer, R., Kroenke, K., Williams, J., & Lowe, B. New York: Pfizer.

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*Beck Depression Inventory–II.* Beck, A. (1996). San Antonio, TX: Pearson Education.

*General Anxiety Disorder-7 [GAD-7].* (2006). Spitzer, R., Kroenke, K., Williams, J., & Lowe, B. New York: Pfizer.

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## Sexual Assault

*Beck Depression Inventory–II.* Beck, A. (1996). San Antonio, TX: Pearson Education.

*General Anxiety Disorder–7 [GAD-7].* Spitzer, R., Kroenke, K., Williams, J., & Lowe, B. (2006). New York, NY: Pfizer.

*Trauma Symptom Inventory–2*. Briere, J. (2010). Odessa, FL: Psychological Assessment Resources (PAR).

## Stalking Victim

*Beck Depression Inventory–II.* Beck, A. (1996). San Antonio, TX: Pearson Education.

*General Anxiety Disorder–7 [GAD-7]*. Spitzer, R., Kroenke, K., Williams, J., & Lowe, B. (2006). New York, NY: Pfizer.

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## Sudden/Accidental Death (Child)

*Beck Depression Inventory–II.* Beck, A. (1996). San Antonio, TX: Pearson Education.

*Family Crisis Oriented Personal Evaluation Scales [F-COPE]*. McCubbin, H. I., Olson, D.H., & Larsen, A. S. (1991). Madison, WI: Family Stress Coping and Health Project, University of Wisconsin–Madison.

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## Suicide (Child)

*Beck Depression Inventory–II.* Beck, A. (1996). San Antonio, TX: Pearson Education Inc.

*Family Crisis Oriented Personal Evaluation Scales [F-COPE.]* McCubbin, H. I., Olson, D.H., & Larsen, A. S. (1991). Madison, WI: Family Stress Coping and Health Project, University of Wisconsin-Madison.

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*Triage Assessment Form: Crisis Intervention, Revised.* Myer, R. A., & James, R. K. (2009). Pittsburgh, PA: CIP-Solutions.

## Workplace Violence

*Impact of Event Scale–Revised.* Weiss, D., & Marmar, C. (1997). New York, NY: Guilford.

*Symptom Checklist–90–Revised.* Derogatis, L. (1994). San Antonio, TX: Pearson Education.

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*Triage Assessment Form: Crisis Intervention, Revised.* Myer, R. A., & James, R. K. (2009). Pittsburgh, PA: CIP-Solutions.

# Appendix D

# RECOVERY MODEL OBJECTIVES AND INTERVENTIONS

The Objectives and Interventions that follow are created around the 10 core principles developed by a multidisciplinary panel at the 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation, convened by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2004):

1. **Self-direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path toward those goals.

2. **Individualized and person-centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

5. **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

7. **Peer support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

8. **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

10. **Hope:** Recovery provides the essential and motivating message of a better future—that people can overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends,

> providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.[1]

The numbers used for Objectives in the treatment plan that follows correspond to the numbers for the 10 core principles. Each of the 10 Objectives was written to capture the essential theme of the like-numbered core principle. The numbers in parentheses after the Objectives denote the Interventions designed to assist the client in attaining each respective Objective. The clinician may select any or all of the Objectives and Intervention statements to include in the client's treatment plan.

One generic Long-Term Goal statement is offered should the clinician desire to emphasize a recovery model orientation in the client's treatment plan.

## LONG-TERM GOAL

1. To live a meaningful life in a self-selected community while striving to achieve full potential during the journey of healing and transformation.

## SHORT-TERM OBJECTIVES

1. Make it clear to therapist, family, and friends what path to recovery is preferred. (1, 2, 3, 4)

## THERAPEUTIC INTERVENTIONS

1. Explore the client's thoughts, needs, and preferences regarding his/her desired pathway to recovery (from depression, bipolar disorder, posttraumatic stress disorder [PTSD], etc.).
2. Discuss with the client the alternative treatment interventions and community support resources that might facilitate his/her recovery.

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[1] From: Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Information Center: Center for Mental Health Services (2004). *National consensus statement on mental health recovery.* Washington, DC: Author. Available from http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

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| | 3. Solicit from the client his/her preferences regarding the direction treatment will take; allow for these preferences to be communicated to family and significant others. |
| | 4. Discuss and process with the client the possible outcomes that may result from his/her decisions. |
| 2. Specify any unique needs and cultural preferences that must be taken under consideration during the treatment process. (5, 6) | 5. Explore with the client any cultural considerations, experiences, or other needs that must be considered in formulating a mutually agreed-upon treatment plan. |
| | 6. Modify treatment planning to accommodate the client's cultural and experiential background and preferences. |
| 3. Verbalize an understanding that decision making throughout the treatment process is self-controlled. (7, 8) | 7. Clarify with the client that he/she has the right to choose and select among options and participate in all decisions that affect him/her during treatment. |
| | 8. Continuously offer and explain options to the client as treatment progresses in support of his/her sense of empowerment, encouraging and reinforcing the client's participation in treatment decision making. |
| 4. Express mental, physical, spiritual, and community needs and desires that should be integrated into the treatment process. (9, 10) | 9. Assess the client's personal, interpersonal, medical, spiritual, and community strengths and weaknesses. |
| | 10. Maintain a holistic approach to treatment planning by integrating the client's unique mental, physical, spiritual, and community needs and assets into the plan; arrive at an agreement |

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| | with the client as to how these integrations will be made. |
| 5. Verbalize an understanding that during the treatment process there will be successes and failures, progress and setbacks. (11, 12) | 11. Facilitate realistic expectations and hope in the client that positive change is possible, but does not occur in a linear process of straight-line successes; emphasize a recovery process involving growth, learning from advances as well as setbacks, and staying this course toward recovery. |
| | 12. Convey to the client that you will stay the course with him/her through the difficult times of lapses and setbacks. |
| 6. Cooperate with an assessment of personal strengths and assets brought to the treatment process. (13, 14, 15) | 13. Administer to the client the Behavioral and Emotional Rating Scale (BERS): A Strength-Based Approach to Assessment (Epstein). |
| | 14. Identify the client's strengths through a thorough assessment involving social, cognitive, relational, and spiritual aspects of the client's life; assist the client in identifying what coping skills have worked well in the past to overcome problems and what talents and abilities characterize his/her daily life. |
| | 15. Provide feedback to the client of his/her identified strengths and how these strengths can be integrated into short-term and long-term recovery planning. |
| 7. Verbalize an understanding of the benefits of peer support during the recovery process. (16, 17, 18) | 16. Discuss with the client the benefits of peer support (e.g., sharing common problems, receiving advice regarding successful coping skills, getting encouragement, learning of helpful community resources, etc.) toward the client's |

agreement to engage in peer activity.

17. Refer the client to peer support groups of his/her choice in the community and process his/her experience with follow-through.
18. Build and reinforce the client's sense of belonging, supportive relationship building, social value, and community integration by processing the gains and problem-solving the obstacles encountered through the client's social activities.

8. Agree to reveal when any occasion arises that respect is not felt from the treatment staff, family, self, or the community. (19, 20, 21)

19. Discuss with the client the crucial role that respect plays in recovery, reviewing subtle and obvious ways in which disrespect may be shown to or experienced by the client.
20. Review ways in which the client has felt disrespected in the past, identifying sources of that disrespect.
21. Encourage and reinforce the client's self-concept as a person deserving of respect; advocate for the client to increase incidents of respectful treatment within the community and/or family system.

9. Verbalize acceptance of responsibility for self-care and participation in decisions during the treatment process. (22)

22. Develop, encourage, support, and reinforce the client's role as the person in control of his/her treatment and responsible for its application to his/her daily life; adopt a supportive role as a resource person to assist in the recovery process.

10. Express hope that better functioning in the future can be attained. (23, 24)

23. Discuss with the client potential role models who have achieved a more satisfying life by using their

personal strengths, skills, and social support to live, work, learn, and fully participate in society toward building hope and incentive motivation.

24. Discuss and enhance internalization of the client's self-concept as a person capable of overcoming obstacles and achieving satisfaction in living; continuously build and reinforce this self-concept using past and present examples supporting it.